Midwives Without Training

Practices and Beliefs of Traditional Birth Attendants in Africa, Asia and Latin America

Yvonne Lefèber

Midwives Without Training

This publication was financially supported by the Africa Museum Berg en Dal – The Netherlands, the Catharina Schrader Foundation and Friesche Vlag Kindervoeding.

STELLINGEN

behorende bij het proefschrift
'Midwives Without Training. Practices and Beliefs of Traditional Birth Attendants in Africa, Asia and Latin America' van Yvonne Leiber

1. Traditionele vroedvrouw zijn is geen beroep (dit proefschrift).

2. Een traditionele vroedvrouw kan alleen zinvol functioneren binnen de eigen sociaal culturele gemeenschap (dit proefschrift).

3. De overeenkomsten van enkele traditioneel verloskundige gebruiken, die in Afrika, Azië én Latijns Amerika voorkomen, vloeien voort uit het feit dat mensen op dezelfde wijze omgaan met basale aspecten van het leven zoals zwangerschap, bevalling en borstvoeding (dit proefschrift).

4. Aandacht voor de overeenkomstige traditioneel verloskundige gebruiken in Afrika, Azië en Latijns Amerika kan van nut zijn voor de Westerse verloskunde (dit proefschrift).

5. Voedseltaboes tijdens de zwangerschap dienen niet zonder meer bestreden te worden (dit proefschrift).

6. Bij de bijscholing van traditionele vroedvrouwen moet uitgegaan worden van hún vaardigheden en ideeën (dit proefschrift).

7. Het effect van een medisch ontwikkelingsproject kan vergroot worden door een (kort) antropologisch vooronderzoek.

8. Afrikaanse moeder- en kindbeelden drukken niet zozeer de affectieve, individuele relatie tussen moeder en kind uit, maar het algemene principe van de vruchtbaarheid.

9. Beschouwt men een oogarts in het Westen soms als een veredelde opticiën, in de Derde Wereld houdt men hem vaak als een god voor ogen.
De ene zienswijze is kortzichtig, de andere overbelicht.

10. Iemand met niet gecorrigeerde lichte tot matige myopie heeft het voordeel alles relatief te kunnen zien.

RIJKSUNIVERSITEIT GRONINGEN

Midwives Without Training

Practices and Beliefs of Traditional Birth Attendants

PROEFSCHRIFT

ter verkrijging van het doctoraat in de
Geneeskunde
aan de Rijksuniversiteit Groningen
op gezag van de Rector Magnificus Dr. F. van der Woude
in het openbaar te verdedigen op
woensdag 7 september 1994
des namiddags te 2.45 uur precies

door

Yvonne Hermine Francisca Lefèber-Mans
geboren op 1 november 1947 te Heerlen

Promotores: Prof.dr. E.R. Boersma
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Prof.dr. A. Niehof

Mtoto mchanga, baada ya kuzaliwa tu, hurambishwa asali na shubiri apate kutanabahi kuwa lazima atafikwa na matamu na machungu katika maisha yake ya duniani

A newly born baby is given some honey and aloes in order to make it realise that it must meet with both sweet and bitter experiences in its life.

A Swahili saying

In memory of Mia, Rika and Tiwa
For Ton, Geeske, Friso and Sarah

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Introduction

"Could you please tell me something about the way you are assisting at birth?" was the very first question I put hesitantly to the old Ghanaian woman of whom I had heard that she was a Traditional Birth Attendant. We were sitting opposite to each other in front of her house being surrounded by a group of women and children who turned out to be her relatives. I hesitated because I felt not sure whether it was polite to ask such a question in public, although 'my' interpreter [a Ghanaian girl] had told me that it would be no problem. In addition I wondered whether the old African woman would accept the question of a younger woman totally unknown to her and obviously coming from a different culture. She looked at me for a while in a serious way. Then suddenly she smiled and started without any hesitation to tell me about her practices at birth ...

Fieldwork Report

The majority of mothers in the countries of Africa, Asia and Latin America are supported by Traditional Birth Attendants (TBAs) during pregnancy and childbirth. A TBA is usually an older woman who has often a family relationship with the pregnant woman. TBAs deliver at least two thirds of all babies in the three continents. As a reaction to the view that the practices of TBAs may endanger mother and child – since the beginning of this century – it has been tried to upgrade the performance of TBAs. Originally this was done by individual physicians or nurses on their own initiative, but from the early fifties official trainingprogrammes were organised in many countries. A systematic approach to the training of TBAs was started by the World Health Organization (WHO) in 1972. In those days the main goal of training TBAs was to improve the perinatal services in Africa, Asia and Latin America where on average one baby out of 12 dies during the first year of life and one mother out of 100 dies during pregnancy and delivery. Many TBAs have been trained in the three continents since 1972. While training in hygiene played a major part in the trainingprogrammes before 1972, later family planning and referral of women to health centres became significant components of the trainingprogrammes. With the introduction of the Primary Health Care (PHC) policy (1978) the WHO recommended exploring the possibilities of engaging TBAs in PHC and training them accordingly. It was argued and propagated that TBAs should work side by side ('articulation') with the organized health system, but they should not be integrated into the system. In this way both the traditional and the organized health system could coexist without any conflict. At present training of TBAs is still promoted for the near future. The main goal

is still to reduce maternal and infant mortality and morbidity and, in addition, to improve reproductive health.

In September 1979 my husband and I together with our children travelled to Africa to stay for a period of 9 months in Ghana. Actually we were returning to Africa as we had previously lived in Tanzania (1972-1975). My husband was requested to replace a Dutch ophthalmologist working in the hospital of Agogo (in Ashanti Region) for 6 months and another Dutch ophthalmologist in Bawku (Upper Region) for a period of three months. I was requested by the District Medical Officer (DMO) who was in charge of Agogo Hospital to do a medical anthropological study of the role, practices and beliefs of the TBAs in Agogo. Investigation of the practices of TBAs was essential for the formulation of a TBA-trainingprogramme in Agogo and the surrounding villages. Agogo was the biggest town of the district Asante-Akim. The DMO had previously started an initial survey as a pilot project in the district to collect data about TBAs. In 18 villages throughout the district a total of 29 TBAs were interviewed. However, the results of the survey were limited. More detailed information about TBAs was required. For that reason I was requested to do a medical anthropological study of the role, practices and beliefs of the TBAs in Agogo.
The fieldstudy was carried out from September 1979 till March 1980. During this period I talked extensively with 15 TBAs. Meeting the TBAs I had the opportunity to increase my knowledge about their work which resulted in more respect for them and initiated a growing interest for the practices and beliefs of TBAs in general. After the fieldstudy I started to make an inventarisation of the practices of TBAs in other countries from the available literature.

This publication is the result of both the inventarisation and the fieldstudy. The main goal of this study is to gain insight into traditional midwifery in Africa, Asia and Latin America.
Three intermediate objectives were formulated:
1 comparing the role, practices and beliefs of TBAs in different countries of the three continents;
2 broadening the insights into traditional midwifery in these countries by classifying the practices and beliefs of TBAs according to the common obstetrical classifications;
3 giving suggestions for a health policy with reference to the training of TBAs.

An analysis of who TBAs are and what they actually do, their characteristics, practices and beliefs has been given in Chapters 1-3. In Chapter 4 trainingprogrammes of TBAs have been analysed. The information in these four Chapters was collected from anthropological and medical publications as well as from nursing journals. The review of the literature is followed by a description of the fieldstudy in Ghana (Chapter 5). At the end of each Chapter a 'Discussion' is given. A 'Final Discussion' (Chapter 6) with conclusions and suggestions for a health policy with reference to TBAs concludes this publication.
A description of general characteristics of TBAs is given in Chapter 1. The practices and beliefs of TBAs in different countries of Africa, Asia and Latin

America (which are compared in Chapter 2) are systematically classified according to the common classifications in 'Western' obstetrics with reference to the perinatal period. This period is divided into the antenatal period, the intrapartum and postnatal period. Descriptions of the practices and beliefs – mainly available from countries where TBAs are given formal training – were traced from sub-Saharan countries in Africa, from countries of South-East Asia (excluding Japan and China) and from countries of Central America (including the Caribbean) and the northern part of South America. Data from Ghana are omitted in this Chapter, but those details are presented in Chapters 4 and 5 where they are more relevant. A comparison is given of the dietary advice as part of the birthing practices of TBAs in the three continents (Chapter 3). Food taboos and/or food recommendations for the pregnant and lactating woman and her child are presented with reference to the antenatal and the postnatal period. The foods are presented according to the Nutritional Classification 'Basic Food Plan' in which every day food is classified as protein-rich foods, foods rich in carbohydrates and fats, foods rich in minerals and vitamins, and water. Data were mainly traced from the same countries as those in Chapter 2. Several training programmes for TBAs are discussed in Chapter 4. A description is given of the learning objectives, course content and evaluation of the performance of the trained TBAs in order to give an insight into the policy concerning TBAs in different places of Africa, Asia and Latin America. Reports of trainingprogrammes which explicitly present these aspects of the training are selected for three countries of each continent.
The fieldstudy in Ghana is presented in Chapter 5. After a profile of the country the health care and the health facilities in Ghana are described. The characteristics of TBAs in different parts of the country are given in addition. This is followed by a description of the study area subdivided into a description of Agogo town, the Asante people and health facilities. The aim of the study is formulated. After a description of the methods and subjects the results of the study are presented. Methods and results which have been presented in the 'Discussion' at the end of every Chapter are reviewed in a Final Discussion (Chapter 6). Suggestions for a health policy with reference to the training of TBAs are given in a final conclusion.

1 Traditional Birth Attendants

1.1 Introduction

It is estimated that between 60-80% of all births in Africa, Asia and Latin America are attended by traditional or indigenous midwives or, to use the term preferred by the World Health Organisation (WHO), *Traditional Birth Attendants* (TBAs). The percentage is an estimate as it is very difficult to obtain reliable data on the number of TBAs and the deliveries they attend. In Haiti, Indonesia and the Sudan the proportion of deliveries attended by TBAs is 80-90%; in some areas of the Sudan [Kordofan; Darfur], Indonesia and India it is more than 90% (Alisjahbana et al.1984; Berggren et al.1983; Chaturvedi 1978; El Hakim 1981; Raina/Kumar 1989; Sciortino 1989).

1.2 Definition

It is very difficult to give a definition of a TBA. The WHO gives as definition

> "A TBA is a person who assists the mother during childbirth and initially acquired her skills by delivering babies herself or through apprenticeship to other Traditional Birth Attendants." (WHO 1992)

The former definition is remarkably alike* and has been mentioned as 'narrow' (WHO 1979). It appeared narrow "in the sense, that, in many cases, the TBA's work includes not only her attendance at childbirth but [also] the provision of basic care to women throughout the normal maternity cycle, the provision of care to the normal newborn, participation in the promotion of modern methods of family planning, and participation in other primary health care activities, including the identification and referral of high-risk patients". But even if these characteristics would be included – in spite of the fact that some of them are contradicting the use of the word 'traditional' – the definition would still be too 'narrow' as there would be no mention of the TBA's participation in the cultural matrix of the social group to which the mother and the TBA belong resulting in for example the right performance of certain protective ceremonies or rituals before, during or after

* "A TBA is a person (usually a woman) who assists the mother at childbirth and who initially acquired her skills delivering babies by herself or by working with other Traditional Birth Attendants." (WHO 1979)

delivery and providing in this way a sense of psychological security for the mother (see 1.3.6).
Analysis of the characteristics, the practices and beliefs of TBAs may contribute to a better understanding of who TBAs are and what they actually do, and this in particular is the aim of the study.

1.3 Characteristics

Descriptions of TBAs and their characteristics are scattered throughout social science publications as well as in medical and nursing journals.
Some authors have characterized TBAs on account of an evaluation of their practices as "native death-angels" [Indonesia] (Van Buuren in Voorhoeve 1965) or "ill-prepared persons likely to create complications in childbirth" (Manley de Carias/Changs 1981), others have given descriptions as "the native methods of *dai* [TBAs] are very abominable, crude and directly responsible for a large proportion of both infant and maternal mortalities" [India] (Lal 1962 in Voorhoeve 1965) or "due to their *(dukun bayi* [TBAs]) ignorance about the physiology and anatomy of the human body, and also not being aware of the state of health of the mothers, mortality is high both for mothers and babies" (Subagio 1974 in Sciortino 1989).
But in general authors have described TBAs as older women who (have had children themselves, have passed child-bearing age, acquired their skills from their family) have achieved their status rather than having it ascribed by birth, are held in great respect by their own community and have the confidence of the people they serve (Akenzua et al. 1981; Baquero et al. 1981; Biersteker 1961; Chaturvedi 1978; Cosminsky 1982/1986; Engelkes 1983; Jordan 1983; Kitzinger 1982; Kuntner 1988; Lam 1991; Le Nobel 1969; MacCormack 1982; Mangay-Angara 1981; Manley de Carias/Changs 1981; Manning 1989; Most van Spijk 1982; Pillsbury 1982; Recio 1986; Subagio 1974; Sujpluem et al. 1981; Timmer 1961; Voorhoeve 1965; West 1981; Williams/Yumkella 1986).
TBAs may explicitly have been described as *'family' TBAs* limiting their services to their relatives only, or as *herbalists or traditional healers* (often a male person) providing antenatal care and more likely to treat complications of pregnancy and delivery (MOH Ghana Final Report 1990; Nicholas et al. 1976; WHO 1992), or as *spiritualists* bringing a woman through her delivery by prayer and divine intervention (Laderman in Kay 1982; Niehof 1993; WHO 1992).

1.3.1 Various local names

Over the whole world there are various local names used to designate TBAs. Table 1.3.1 summarizes the names used in different countries (those from other references as the WHO report are separately indicated).
The use of different languages in one country may lead to different titles: in Guatemala, for instance, the TBA is called an *iyom* or *ilonel* in the local language [Quiché] and *comadrona* in Spanish (Cosminsky 1982).
Within one country there are possibly more titles used to identify TBAs which may vary according to ethnic groups. In the Philippines for example: the Tagalogs call a TBA a *hilot*, the Sulods a *partira* or *baylan* and the Tausugs a *panday* (Recio 1986).

Table 1.3.1 Local names of Traditional Birth Attendants

AFRICA		
Country (in alphabetical order)	Local name	Remarks
Benin	Matrone	FromLatin 'mater' = mother
Cameroon	»	
Chad	»	
Dahomey	»	
Egypt	Daya	Also spelt 'dayah'
Gabon	Matrone	From Latin 'mater' = mother
Ghana	Deogyeamo Yei-ni-fomo	Meaning 'women who deliver other women'
»	Ogyeawoo Mirojiaura	Meaning 'birth receiver'
»	Nea ogye awo[1)] Awo gyefo	Meaning midwife Meaning somebody who knows how to deliver women
Guinea	Matrone	
Guinea Bissau	Partera di casa	Domiciliary midwife
Ivory Coast	Matrone	
Kenya	Matrone	
»	Mwisikya[2)] Mwisikya Mwai	
Lesotho	Babele Xisi	
Liberia	Empirical Midwife	Also referred to as 'Traditional Midwife' or 'Indigenous Midwife'
Libyan Arab Republic	Daya	
Malagasy Republic	Renin-jaza	Meaning 'mother of children'
Malawi	Mzamba namwino	
»	A docotola	A corruption of the English word doctor
Mali	Matrone	
Mauritius	Dai	
Morocco	Qabla	
Niger	Matrone	
Nigeria	Unguanzoma	
Rwanda	Ababyaza	Meaning 'mother of children'
»	Accoucheuse Traditionnelle	
Senegal	Matrone	
Sierra Leone	Bundo or Bunda Mamy	

Table 1.3.1 Continuation

Country	Local name	Remarks
	AFRICA	
Somalia	Omolesso Guddo[3]	Also spelled 'umilisses'
Sudan	Daya El Habil	Meaning 'rope midwife'; title due to the technique of utilizing a rope during delivery
	Khafedha[3]	
Tanzania	Mkunga wa jadi[4]	TBA in Kiswahili; plur.: Wakunga wa jadi
	Mlala[5]	
Togo	Matrone	
Tunisia	Matrone Qabla[6]	Meaning 'she who receives"; plur.: qablat
Upper Volta	Matrone	
Zambia	Mutumbusi	
Zimbabwe	Ambuya	'Shona' name for grandmother
	ASIA	
Country	Local name	Remarks
Afghanistan	Dai	
Bangladesh	"	
Burma	Let-the	
Democratic Kampuchea	Matrone	
Ellice Islands	Tofunga	
Fiji	Allewa Vuku	
Gilbert Islands	Tia Kabung	
India	Dai	
Indonesia (Central and East Java)	Dukun-Bayi	'Dukun-Bayi' [or 'Dukun Beranak'] means 'those rendering assistance during childbirth'
" (West Sumatra)	" [7]	
" (West Java)	Pataji	
" (Sumatra [Toba Batak])	Sibaso	
" (Madura)	Dukon Rembi'	
" (Bali)	Balian Manak[8]	'Balian' is the generic name for traditional magico-medical experts
Lao People's Democratic Republic	Matrone	

Table 1.3.1 Continuation

Country	Local name	Remarks
	ASIA	
Malaysia	Bidan	Also referred to as Kampong Bidan or Bidan Kampung
	Bidan beranak[9]	
	Bidan pelihara	
Maldives	Fooluma	
Nepal	Sureni	
Pakistan	Dai	
Papua New Guinea	Bidan	
Philippines	Hilot	Meaning 'massage'. In some provinces she is referred to 'magpapaanak' or 'mananabang'
"	Partira, baylan or panday[10]	
Sri Lanka	Gode-Vinappa	
"	Amma	
Thailand	Moh. Tam. Yae	
"	Mee-hab	
Timor	Wata Sitong	
Viet Nam	Matrone	
"	Ba Do Vuon	
"	Ba Mu Vuon	
	LATIN AMERICA	
Country	Local name	Remarks
Argentina	Comadrona	Meaning co-mother of her clients, by virtue of being the God-mother to their children
Barbados	Nanny	Meaning 'nursemaid'
Belize	"	" "
Bolivia	Partera Empirica	Also referred to as Empirica or 'Partero Empirico'
Brazil	Curiosa	
Chili	Partera Empirica	
Colombia	" "	
Costa Rica	" "	
Cuba	Recogedera	Meaning 'one who catches the baby'
Dominican Republic	Partera Empirica	
	Local Midwife	
Ecuador	Comadrona	

Table 1.3.1 Continuation

Country	Local name	Remarks
	LATIN AMERICA	
El Salvador	Partera Empirica	
Grenada	Femme Shi	Also referred to as 'bush-midwife'
Guatemala	Comadrona	
"	Iyom or ilonel[11]	
Guyana	Nanny	Meaning 'nursemaid'
Haiti	Matrone[12]	
	Femme Sage	There are also male TBAs called 'homme-sage'
Honduras	Partera Empirica	
Jamaica	Nana	Meaning 'grandmother'
Mexico	Comadrona	
"	Partera Empirica	
Montserrat	Bush Midwife	Rural Midwife
	Nicaragua	Comadrona
"	Partera Empirica	
Panama	Partera Empirica	
Paraguay	Chaé	Also referred to as Empirica
Peru	Comadrona	
"	Partera Empirica	
St. Lucia	Femme Charge	
Surinam	Granny	Meaning grandmother or old woman
Trinidad and Tobago	Middy	
Uruguay	Comadrona	

Sources: Verderese M. de Lourdes & Turnbull L.M. 1981
1) Lefèber 1984 2) Voorhoeve et al. 1984 3) van Nispen 1990 4) Mmuni 1992 (personal communication) 5) Moller 1961 6) Bartels 1993 7) van Oosterhout 1993 8) Niehof 1992/1993 9) McArthur 1961 in Voorhoeve 1965, 10) Recio 1986 11) Cosminsky 1982 12) Berggren et al. 1983

Within the same ethnic group one can find different titles for two 'kinds' of TBAs: for example in Machakos district (in Kenya) a TBA is either a *mwisikya* or a *mwisikya mwai*. The *mwisikya* is "usually an older woman, past child-bearing age, who assists in the delivery at the woman's home and who does not depend on midwifery as a source of income. She gains her knowledge through experience and/or by assisting other *mwisikya*." The *mwisikya mwai* is a TBA who "depends entirely on midwifery as a source of income and has a special place for delivery at her home where women also come for antenatal care" (Voorhoeve et al. 1984).

The Asante in Ghana use the titles *nea ogye awo* and *awo gyefo*. *Nea ogye awo* is used for midwives in general: TBAs as well as midwives in the hospital, whereas *awo gyefo* is used for TBAs, or better, for all the persons who know how to assist a woman in labour, but without a medical education (Lefèber 1984). In Malaysia, the local names *bidan beranak* and *bidan pelihara* are used. The *bidan beranak* is a TBA who assists the woman in labour, takes care of the placenta and washes the polluted clothes. The *bidan pelihara* is a TBA who takes care of the mother immediately after delivery; she gives massage to the mother, bathes the mother and the newborn and does the domestic work during the days after delivery (Mc Arthur 1961 in Voorhoeve 1965).

1.3.2 Gender of the TBA

The majority of TBAs are women. Male TBAs, usually herbalists providing antenatal care and treating complications of pregnancy and delivery, have been reported in a few cultures only, e.g. in Ghana, Nigeria, Bolivia, Colombia, Ecuador, Honduras, Indonesia and the Philippines (Akenzua et al. 1981; Baquero 1981; Clastres 1972; Freedman in Voorhoeve 1965; Korfker 1982; Mangay-Angara 1981; Manley de Carìas/Changs 1981; Nicholas et al. 1976; Niehof 1992; Otoo 1973; Smits 1992, personal communication; Subagio 1974)(see also 1.3).
A survey of 30 893 TBAs in the Philippines showed that16% were men. These male TBAs were practising in all 11 regions of the Philippines while the proportion in each region ranged from 6% to 35%. In a few areas of the country they outnumbered the female TBAs. Similar to the findings of a survey in Ghana (see 5.1.3) the male TBAs were often herbalists (Mangay-Angara 1981). In Honduras only "a few men" were TBAs (Manley de Carìas/Changs 1981).

1.3.3 The way of becoming a TBA

Most of the authors report that female TBAs acquire their skills on learning by doing, usually when they are young. They join their (grand)mother or aunt and watch and listen while she is assisting at the birth. They continue to do so until the elder TBA indicates that she is no longer able to do the work: then they take over and become TBAs. At that time they may have themselves given birth to children and often passed childbearing age. TBAs may tell that they have acquired their skills from God or spirits as they have been 'called' by some supernatural experiences such as a dream or a vision (Bartels 1993; Berggren et al. 1983; Cosminsky 1982b; Jordan 1989; Kay 1982; Kitzinger 1989; Lam 1991; Manning 1989; Niehof 1985/1992/1993; van Oosterhout 1993; West 1981).
A few authors state that some of those TBAs have learned their practices from a public health midwife or a physician [while working in health establishments] (Baquero et al. 1981; West 1981b). The literature doesn't seem to give any information how the male herbalist TBAs acquire their skills.
Historically TBAs were all illiterate, but nowadays in some places (e.g. Philippines; Bangladesh) TBAs have passed school examinations (Amin/Khan 1989; Mangay-Angara 1981).

1.3.4 Number of deliveries

It is very difficult to obtain reliable data on the number of deliveries a TBA may attend. The average number of births attended yearly by each TBA may vary from 0 to more than 30 (Baquero et al. 1981; Mangay-Angara 1981; Manley de Carias/Changs 1981; Nicholas et al. 1976; West 1981b). The number of deliveries attended by TBAs differ from person to person. Apparently the successful TBAs, who command great respect, may have more clients than others: some TBAs may attend up to 120 births per year (MacCormack 1982; WHO 1992).

1.3.5 Payment

In general TBAs do not rely on deliveries in order to subsist. Most TBAs have other occupations as a primary means of earning their living: they often work as farmers, but they may also work as domestics, traders or handicraft workers (Akenzua et al. 1981; Mangay-Maglacas 1981; Nicholas et al. 1976; van Oosterhout 1993).
TBAs are generally rewarded for their services either in cash or in natura like food, clothes and other gifts (Akenzua et al. 1981; Edwards et al. 1989; Lam 1991; MacCormack 1982; Manning 1989; Most van Spijk 1982; Niehof 1988/1992; van Oosterhout 1993). Reports from Colombia, Ecuador and Honduras indicate that TBAs charge according to the difficulty of the delivery, the sex of the child, the time of the delivery (i.e. day or night), the kin relationship of the TBA to the mother, the woman's financial situation, the amount the woman wishes to give or the lenght of time spent with the mother and the types of chores performed (e.g. washing clothes, cooking, cleaning) (Baquero et al. 1981; Manley de Carìas/ Changs 1981; Smits 1992, personal communication). Sometimes TBAs do not charge fees for their work as they render services "for God's sake" (Akenzua et al. 1981) or when they know that the woman's family is very poor (Manley de Carìas/Changs 1981). They may also attend deliveries out of charity only (West 1981b) or accept any act of appreciation such as being a guest of honor at a dinner party in celebration of the birth of the baby (Ityavyar 1984; Lam 1991).

1.3.6 Additional activities

TBAs do more than only delivering babies (see 1.2). Being part of the local community they are acquainted with the women and their families with whom they share the cultural ideas about how birth has to be prepared and performed. They know the local medicines and rituals that are used before, during and after delivery. They act as consultants on diseases of women and small children. They may give advice on vomiting, oedema, diet, physical work and on *traditional* methods of contraception or of promoting fertility. They may assist women in performing abortion – or they may not want to have anything to do with it as in Madura in Indonesia (Niehof 1988) – and they may perform female circumcision (El Hakim 1981; Lam 1991; MacCormack 1982; Mangay-Angara 1981; Measham et al. 1981; Most van Spijk 1982; Namakforoosh 1984 in Bijsterveld 1990; Niehof 1988/1992; van Oosterhout 1993; West 1981).

Communication with the ancestral and supernatural world seems to be an essential part of the expertise of TBAs. They claim to be aware of good and bad spirits and are supposed to be able to resist possible bad influence from evil spirits. This may provide a sense of psychological security for the mother (Akenzua et al. 1981; Chalmers 1990; Cosminsky 1982; Jordan 1989; Kay 1982; Kitzinger 1989; Laderman in Kay 1982; Lam 1991; Niehof 1992/1993; Voorhoeve 1965; West 1981). Sometimes TBAs are *not* equipped to deal with spiritual agencies (Blanchet 1984).
TBAs must not be afraid of dealing with possible catastrophic events that may occur at birth. In addition they need a lot of tact not to speak of what they have seen or done as they may deal with the practice of infanticide. MacCormack(1982) reports, for example, from the Mende and Sherbro in Sierra Leone that if the infant is abnormal at birth or considered to be a 'witch' child, the TBA may perform infanticide (e.g. by preventing the mother from feeding the infant) and tell the relatives and neighbours that the woman delivered a stillborn child. In this way she is protecting the mother from social repercussions: people may treat her as an outcast on account of delivering an abnormal child which is often seen as a reincarnation of a malevolent spirit. Similarly it has been reported from the Bariba in Benin that TBAs may decide to destroy the infant if it is considered to be a 'witch' child* (Sargent 1982). (TBAs are the persons that have to tackle this kind of problems). But it should be remarked that not *all* TBAs have to deal with the practice of infanticide: it all depends on the way the culture to which the TBA belongs has developed its sets of beliefs and customs for coping with the birth of a child that is (or is considered to be) abnormal.

1.4 Discussion

In conclusion to this chapter it appears that the term TBA is used – at least by the WHO – as a collective noun for all those persons who know how to assist women at childbirth. In this way TBAs are considered as one category or a professional group. However bearing in mind the characteristics of TBAs in the various communities of all countries in Africa, Asia and Latin America one should be careful of treating them as *one* group. Common characteristics seem to be: 1) the age – they are generally old –, 2) the gender – they are mostly women –, 3) the way of becoming a TBA – most TBAs acquire their skills from family –, and 4) the fact that they do not rely on deliveries for subsistence.
But other characteristics show wide diversity.

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* For the Bariba "the signs indicating a witch child are: 1) a breech birth, 2) a child which slides on its stomach at birth, 3) a child born with teeth, 4) a child born with extreme birth defects, 5) a child born at 8 months (lunar months), or 6) a child whose teeth come through first in the upper gums". A witch child is believed to be "capable of killing its mother during delivery or of growing up to provoke havoc among its relations". Because a witch "represents one of the major causes of misfortune" and "birth is the moment when a witch arrives on earth it must [then] be apprehended" (Sargent 1982).

- There are obviously different kinds of 'TBAs':
  a TBAs who do deliveries only occasionally mostly restricting their services to their own relatives *('family' TBAs)*,
  b TBAs who have a regular practice assisting their relatives as well as women who are not related to them,
  c TBAs who are primarily *herbalists* (often male) treating mainly complications of pregnancy and delivery, and
  d TBAs who are *spiritualists* depending on prayer and divine intervention to bring a woman through her delivery,
  e TBAs who restrict their work to assisting the woman in labour, taking care of the placenta and washing the polluted clothes as there are other TBAs in the same place who are in charge of taking care of the mother and child in the postnatal period by giving massage to the mother, bathing her and the child and doing domestic work during the days after delivery (see 1.3 and 1.3.1).
- There are more and less experienced TBAs according to the great variety in the number of deliveries attended yearly by each TBA.
- TBAs get varying rewards for their services. Being part of the local community and therefore acquainted with the women, their families and the local customs TBAs know very well what kind of remuneration they can charge or expect for their services.
- There is a great variety in the birthing practices and beliefs of TBAs as will be described in Chapter 2 and 3. Apart from their medical and technical skills TBAs differ also in their socio-cultural knowledge and skills. TBAs are strictly bound to the social and cultural matrix to which they belong (their practices and beliefs being in accordance with the needs of the local community). Therefore they may not be able to assist women at childbirth outside their own socio-cultural environment (see 1.2 and 1.3.6).

2 Practices and Beliefs of Traditional Birth Attendants During the Perinatal Period

Review of the Literature

2.1 Introduction

Descriptions of the practices and beliefs of traditional birth attendants (TBAs) in the three continents Africa, Asia, and Latin America, as described in social science as well as in medical and nursing publications, are presented in relation to the stages of the birth process. A distinction is made between *physiological* and *pathological* conditions according to Western obstetric standards. 'Physiological' applies to the normal expected pregnancy and labour without any assistance. 'Pathological' applies to situations that deviate from normal pregnancy, labour and the postpartum period (e.g. when postpartum haemorrhage occurs, or when the child presents in a breech or a transverse position).
For practical (obstetric) reasons the birth process is divided into 3 periods:

1 antenatal period = period of pregnancy until birth.
2 intrapartum period = period of birth, divided in:
   a the first stage of birth: dilatation. This stage lasts from the beginning of the (strong) contractions until complete dilatation of the cervix (± 10 cm),
   b the second stage of birth: expulsion of the child. This stage lasts from the descent of the child into the birth canal until complete expulsion of the child,
   c the third stage of birth: the birth of the placenta. This stage lasts from the birth of the child until the birth of the placenta.
3 postnatal period = period of care of mother and child after birth.

These three periods combined are also called the *perinatal period.* This most critical period of life has been defined for international use by the WHO (1991) as the time span from 28 weeks of gestation up to the first week of life [up to 6 days of age]. In relation to mortality the period has been subdivided: *perinatal mortality* includes late fetal deaths or stillbirths (> 28 weeks of gestation or >1000 g) and early neonatal deaths (first week of life).

2.2 Africa

2.2.1 The antenatal period *(physiological)*

2.2.1.1 PRENATAL CARE

An important part of the TBAs' prenatal care exists of *providing herbal medicines* which are usually made from the roots, bark or leaves of locally available plants. This has been reported from Kenya [Akamba; Digo people]; Malawi; Nigeria [Annang; Edo people]; Sierra Leone [Mende people]; South Africa [Sotho; Zulu; Xhosa people]; Tanzania [Wahehe; Wanyakyusa people]; Zambia [Tonga people] and Zimbabwe (Akenzua et al. 1981; Bullough/Leary 1982; Chalmers 1990; Ityavyar 1984; Kuntner 1988; Larsen et al. 1983a; Le Nobel 1969; Mapondera 1989; Moller 1961; Mutambirwa 1985; Solomon/Rogo 1989; Voorhoeve, A. 1979; West 1981).

Bullough/Leary (1982) have reported from Malawi that these medicines are prepared as an infusion* to be taken orally. "The dose may vary from one spoonful weekly to a cupful four times daily. Sometimes the powdered bark or root is taken by being added to porridge."

The medicines serve different purposes such as treating abdominal pain, preventing abortion, ensuring a safe pregnancy, keeping the foetus slim, making the pregnant woman strong, enlarging the birth canal, inducing stronger contractions during labour, ensuring a strong child, preventing maternal oedema or the presence of vernix on the newborn or they may facilitate placental delivery (Bullough/Leary 1982; Chalmers 1990; Solomon/Rogo 1989; West 1981). Herbal medicines provided during pregnancy by TBAs, for example, in Malawi are summarized in Table 2.2.1.1a.

West (1981) states that the TBAs and their clients believe strongly in the special qualities of these medicines and their effects. A special remark about belief in relation to the medicines is worthwhile to take into account here: "A large number of herbal medicines serve the purpose of correcting either constipation or diarrhoea, conditions with which the people are very concerned. A 'dirty stomach', the phrase used to describe the condition of not having had a bowel movement and also to explain diarrhoea, is of particular concern for pregnant women, as the gastrointestinal tract and uterus are believed to be connecting organs." Concern about a 'dirty stomach' has been noted also by Bullough/Leary (1982): "There is a common belief that the 'way' should be cleansed so that the baby will be free from infection, and this is done by prescribing medicine which has supposedly both a diuretic and a laxative action." Larsen et al. (1983a) have reported from South Africa the TBAs' advice to use the herbal infusion *Isihlambezo* during pregnancy. This herbal infusion varies in its constituents from place to place. "It is used to prevent oedema and to ensure that the baby is clean at birth and not

* Infusion = liquid made by soaking herbs in (usually hot) water to extract flavour or ingredients for a medicine.

Table 2.2.1.1a Herbal medicines used by TBAs in Malawi during pregnancy

Vernacular name of herbal medicine (scientific name in brackets)	Purpose
'Mtsatule' (Allophylus africanus, A. Chaunostachys)	may have a diuretic and laxative action
'Mlambuzi' (Cissus cornifolia)	may relieve pains in pregnancy
'Namwalicheche' (Cyphostemma sp.)	unknown
'Palibekanthu' (Dicoma-kirkii)	may promote appetite, clean the bladder and the inside of the body
'Mlimbikira' (Indigofera antunesiana)	may prevent abortions
'Nthoci' = banana (Musa paradisiaca)	may prevent premature labour
'Mtukumphako' or 'Mtukambako' (Ozorea reticulata var. crispa)	may relieve abdominal pains and improve the circulation
'Choosi' (Sida acuta)	unknown
'Mwaye' or 'Mteme' (Strychnos spinosa)	may have a diuretic and laxative action, relieve abdominal pains and improve the circulation
'Kamtsokoya' (Uapaca nitida)	may increase urine output

Source: Bullough/Leary 1982

covered with vernix*" (which is often seen as sperm, a shameful thing suggesting the result of intercourse during pregnancy – see also 2.3.5.3).

Another part of prenatal care consists of *massage of the abdomen* as recorded in Ghana [Ga people] and Kenya [Akamba people] (Otoo 1973; Voorhoeve, A. et al. 1979/1984). How this massaging is performed is described by Otoo (1973): the TBA "puts her arms around the mother from behind, and jerks the uterus from side to side". In addition Otoo states that "this is supposed to alter the position of the foetus which, it is believed, will otherwise lie in one place causing pressure symptoms which might deform it, or cause untoward symptoms in the mother, such as vague aches and pains and debility". Voorhoeve A., et al (1984) report something similar: the TBA "tended to attribute the lower abdominal pain to a wrong position of either the fetus or the placenta and to treat it by massaging the woman's abdomen with warm hands smeared with butter or soap. The TBA claimed that this turned the baby and the placenta as well into the right position." In Kenya [Digo people] TBAs are performing *abdominal palpation* in order to identify different types of fetal presentation or to recognise multiple pregnancy (Solomon/Rogo 1989).

From Mozambique and Zambia [Tonga people] (Korfker 1987, personal letter; Le Nobel 1969) it has been reported that TBAs instruct the pregnant women how to

* Vernix caseosa = a fatty substance secreted by the skin glands of the foetus, usually seen in preterm born infants

stretch and massage the vagina. There is only one description of this practice: "During the last few months of the pregnancy a special method is applied in order to prepare the birth canal for the delivery. Both the TBA and the expectant woman try to widen the vagina by inserting a clenched fist completely, whereafter it is slowly withdrawn. If this can not be done, the birth canal is supposed to be too narrow. .... It is claimed by the TBAs that manual dilatation is a useful and proper method to facilitate a delivery." (Le Nobel 1969)

Promoting adherence to taboos on activities [and food; see Chapter 3] also belongs to the TBA's prenatal care. This is indicated in Kenya [Digo people], Nigeria [Annang people], Sierra Leone [Mende people], South Africa [Sotho; Zulu; Xhosa people], Tanzania [Wahehe; Wachaga; Bahaya people], Zambia [Lozi; Mbunda people] and Zimbabwe (Chalmers 1990; Ityavyar 1984; Mapondera 1989; Moller 1961; Mutambirwa 1985; Solomon/Rogo 1989; West 1981; van Zanden,1988). West (1981) noted that people believe in witches and bad influences from a supernatural world and that certain precautions must be taken in order to protect the mother and fetus against these forces. In addition it is stated that "most of the pregnancy-related codes of conduct are based on the idea that the child in utero imitates its mother and can be affected in its development by forces acting in or on the mother." (see also 2.3.1.1)
TBAs in Kenya [Digo people] advise mothers to avoid sexual intercourse during pregnancy as it may cause either neonatal vomiting or a lot of "semen" covering the baby's skin at birth (vernix caseosa)(Solomon/Rogo 1989).
Some of the taboos on activities during pregnancy in Sierra Leone are summarized in Table 2.2.1.1b.
Chalmers (1990) reported from South Africa some taboos being imposed on pregnant Sotho, Zulu and Xhosa women, which are summarized in Table 2.2.1.1c.
In addition Larsen et al. (1983a) have reported from South Africa [Zulu people] that TBAs may advise pregnant women to be as active as possible, especially in early pregnancy, and to use coitus interruptus from the seventh month of pregnancy onwards.
Moller (1961) has given descriptions of some taboos on activities during pregnancy in Tanzania. For comparison these taboos are similarly summarized in Table 2.2.1.1d.
Taboos on activities during pregnancy in Zambia [Lozi; Mbunda people] are summarized in Table 2.2.1.1e.

Giving *information on childbirth to a primigravida* may also be part of the prenatal care. From Senegal [Diola people] it has been reported that the primigravida is informed by a TBA about everything of the delivery. The pregnant woman is told how labour starts and what she has to do when it starts (Korfker 1983). Chalmers (1990) has indicated from South Africa [Sotho, Xhosa, Zulu people] that traditionally information about everything of the delivery is made known to pregnant women. However, a report from Sierra Leone [Mende people] indicates that "a primigravida is given no information on childbirth prior to labour; it is believed that knowledge of the event would make her so frightened that she would seek an abortion" (West 1981).

Table 2.2.1.1b Taboos on activities during pregnancy in Sierra Leone [Mende people]

Taboos on activities	Argument
Standing in the doorway	may cause obstructed labour
Standing with arms crossed over breast	may cause obstructed labour
Sleeping too much and not moving about	may cause uterine inertia and dull child
Going halfway on any journey and then returning to place of origin	may cause prolonged and difficult labour
Washing heavy clothing	may cause abortion
Lifting heavy loads	"
Intercourse after sixth month of pregnancy	"
Extramarital intercourse	"
Dreaming of extramarital intercourse	"
Talking about unborn child or making preparation for its arrival (e.g. purchasing or making clothes)	may cause various problems by drawing attention of witches who may use words or articles as vehicle for evil curses
Wearing new clothes during pregnancy	
Sitting on the edge of a wooden bed	may cause sunken fontanelle
Splitting wood	may cause prematurity
Fishing too long	"
Planting rice	"
Drinking leftover ('stale') water	"
Engaging in antisocial behaviour, e.g., arguing with co-wives, friends, husband, or other contacts	may cause various problems by drawing evil spirits and creating potential for curse to be invoked
Wearing a brassiere or tossing one's lappa* around neck	may cause nuchal cord
Bathing at night	may cause fetal abnormalities since these practices will draw evil spirits
Walking about at night without protection of a stone or knife tied in one's lappa*	
Resting in an easy chair or hammock	may cause face presentation
Standing at crossroads	may cause transverse lie and difficult labour

* lappa = sarong-type skirt
Source: West 1981

Table 2.2.1.1c Taboos on activities during pregnancy in South Africa [Sotho; Zulu; Xhosa people]

Taboos on activities	Argument
Moving on certain pathways that may harbour the evil spirits of wizards, witches or wild animals	may harm the baby
Plaiting hair	may form a knot in the umbilical cord
Sleeping during daylight	baby may behave in the same way on its delivery day
Peeping through doors or windows	the fetal head may protrude and recede but not proceed through the vaginal canal at delivery
Sexual intercourse during the last trimester of pregnancy	may result in a vernix ("sperm")* coated baby at birth

* see 2.2.1.1, pg. 16
Source: Chalmers 1990

Table 2.2.1.1d Taboos on activities during pregnancy in Tanzania

People	Taboos on activities	Argument
Wahehe	sexual intercourse	unknown
	wearing tight fitting clothes and knots tied on clothing	"
Wachaga	getting drunk	"
	laughing at anything ugly or fearsome	"
	eating together with a woman who has had a miscarriage	"
	walking under a stick, carrying a heavy bunch of bananas	may cause the child to 'get caught' during the birth
	moving backwards through a door or an entrance	may cause an obstructed labour
	sitting on a bed	unknown
	crossing a stream of flowing water	"
	insufficient chewing of all food and insufficient 'chewing' of all fluids	may cause a fetus hurt by lumps of food falling on it
	eating fast and swallowing big pieces of food	may cause the fetus to choke as its is believed that whenever the mother eats the fetus eats as well

Source: Moller 1961

Table 2.2.1.1e Taboos on activities during pregnancy in Zambia [Lozi; Mbunda people]

Taboos on activities	Argument
Sitting with legs crossed	may cause obstructed labour
Going for a walk and returning halfway	may cause weak contractions
Carrying something in both hands	may cause a sixth finger or toe of the child
Sexual intercourse after the sixth month	may cause a lot of vernix ("sperm")* which will lead to laughter of the people

* see 2.2.1.1, pg. 16
Source: van Zanden 1988

2.2.2 The antenatal period *(pathological)*

2.2.2.1 Bleeding during pregnancy

From a study in Kenya [Akamba people] (Voorhoeve A. et al. 1979) it is learned that bleeding during pregnancy is for 11 out of 18 interviewed TBAs a reason to *send a woman to the hospital;* 2 of them will turn the baby and 2 other TBAs will give herbs. It is not indicated what the other 3 TBAs would do.
Larsen et al.(1983a) report from South Africa [Zulu people] that TBAs appear to have no understanding of the causes and treatment of antepartum haemorrhage. They may try *traditional treatments.* Unfortunately a description of these treatments is not presented.

2.2.2.2 Breech presentation

In case of a breech presentation TBAs are able to *turn the fetus* according to reports from Kenya [Akamba; Digo people], Nigeria [Edo people] and Tanzania [Wahehe people] (Akenzua et al. 1981; Moller 1961; Rebel 1988; Solomon/Rogo 1989; Voorhoeve, A. et al. 1979/1984). TBAs in Machakos district in Kenya (Voorhoeve, A. et al. 1984) intend to turn the fetus by *massaging the abdomen* (see 2.2.1.1). TBAs in Kitui district and Kwale district, however, perform *external version.* In Kitui district external version is done shortly before the delivery; the TBAs indicated that this is only possible as long as the child's head is not engaged in the pelvis and as long as the membranes are not ruptured (Rebel 1988). A report from Tanzania doesn't give any description of this practice; it is only stated that a TBA is able to recognize a breech presentation and "might even be capable of correcting it" (Moller 1961).
Kuntner (1988) indicates that in case of a breech presentation a TBA in South Africa [Zulu people] will try to change this presentation by either external version or *firmly shaking.*
In Malawi TBAs may give a *herbal medicine* [see Table 2.2.3.1c] in order to correct presentation (Bullough/Leary 1982).
From Zambia [Tonga people] it has been reported that TBAs are able to recognize the difference between cephalic and breech presentation but they don't try to change it (Le Nobel,1969).
In addition, TBAs from Nigeria [Annang people] "do allow women to deliver with a breech presentation" (Brink 1982).

2.2.2.3 TRANSVERSE PRESENTATION

TBAs in Kenya [Digo people] and Nigeria [Annang people] "use *external cephalic version* (ECV)* when they find that the fetus is in the transverse lie" (Brink 1982; Solomon/Rogo 1989). In case of a transverse presentation in Sierra Leone [Mende people] a woman is given either *a hot bath* or *hot palm oil applied on her abdomen* while she is lying on her side facing a fire. The heated abdomen may stimulate the fetus to turn (MacCormack 1982).

2.2.2.4 INTRAUTERINE DEATH (STILLBIRTH)

Only one report about intrauterine death in relation to the management of TBAs has been detected. In this report, coming from Benin [Bariba people], it has been stated that TBAs diagnose intrauterine death on cessation of fetal movement or of contractions by interrogating the parturient while observing and palpating her abdomen. They give the woman a *medicine* which has to be taken *orally* to stimulate contractions which may accelerate the delivery of a stillbirth (Sargent 1982).

2.2.3 The intrapartum period *(physiological)*

2.2.3.1 FIRST STAGE

2.2.3.1a *Immediate preparation*

There are not many descriptions of the immediate preparation for delivery. From several reports, though, one gets the impression that in general there is *little immediate preparation*: only some equipment (rags, pots for water, an instrument to cut the cord) is kept ready. West (1981) is one of the authors who gives a description of it. She reports from Sierra Leone [Mende people] that little immediate preparation is made by either the TBA or the pregnant woman and that "the facilities and equipment generally consist of a woven mat for the mother to lie on, homemade soap for washing the baby and/or the TBA's hands, pots for water and to mix medicine in, a razor blade, kitchen knife or small machete to cut the cord, and a clean cloth or rags to wrap the baby in and to clean up afterwards".

Mapondera (1989) reports from Zimbabwe that the floors of the hut in which the delivery takes place are swept clean and that a fire is made to keep the room warm for the mother and the baby.

In South Africa [Zulu people] "a fire is usually made in the hut in which the birth is taking place to ensure the baby's arrival into a warm environment as the dangers of hypothermia are recognized". (Larsen et al. 1983a)

Brink (1982) observed in Nigeria [Annang people] that some yam leaves were kept ready. At the end of the first stage of labour a TBA "called for three large yam leaves, which were brought. One was placed under the woman's buttocks, the other placed beside her. A third was given to the TBA who used it to wipe her fingers after doing the pelvic examinations."

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* Using ECV means that they try to manipulate the fetus into a cephalic presentation by external version.

From Kenya [Akamba people] another part of preparation has been reported: "... the abdomen of the woman-in-labour is washed with warm water. (It is claimed that cold water would make the child folded and by this hinder the delivery)" (van Ginneken et al.1984 in Rebel 1988).

2.2.3.1b *Physical examination*
TBAs may perform an *external examination* according to reports from Kenya [Akamba people], Sierra Leone [Mende people] and South Africa [Zulu people] (Jepson/MacDonald 1988; Rebel 1988; West 1981). Rebel (1988) states that "the contractions and the child's position are palpated or observed during the delivery. .... The contractions are examined for strenght and frequency. .... The position of the child is observed or palpated in order to know whether the child has descended into the pelvis or not and to know the position of the child." West (1981) indicates that the TBA "palpates the abdomen [of the woman] to determine the presentation and degree of engagement. She may also put her head on the fundus to listen for sounds or to feel for fetal movement". In Zambia [Tonga people] external and vaginal examination are omitted, unless there is a delay (Le Nobel 1969). TBAs in South Africa make "an initial examination of the abdomen to determine the position and lie of the baby". The TBAs appeared to be "able to assess, by abdominal palpation, whether the contractions were increasing or decreasing in strength and frequency, but unable to assimilate this information to alter their management" (Jepson/MacDonald 1988).

Vaginal examination in order to assess the cervical dilatation may be performed by TBAs in Kenya [Akamba people], Nigeria [Annang people], Sierra Leone [Mende people] and Zambia [Tonga; Lozi; Mbunda people] (Brink 1982; van Ginneken et al.1984 in Rebel 1988; Le Nobel 1969; MacCormack 1982; West 1981; van Zanden 1988). This examination is conducted by reaching two or three fingers up into the vagina. The TBAs' hands may or may not always be washed with water and soap before the performance of a vaginal examination.
Some TBAs rupture the membranes; this has been reported from Kenya [Akamba people] (van Ginneken et al. 1984 in Rebel 1988). If vaginal examination is required, TBAs of the Zulu in South Africa recognize "the need to wash the hands and use a vaginal lubricant [frequently the herbal medicine with the vernacular name 'Isihlambezo']" (Gumede 1978; Larsen et al. 1983 in Chalmers 1990). 2 TBAs out of 14 interviewed TBAs in South Africa [Zulu people] performed vaginal examination with any frequency. "This was not done to monitor the degree of cervical dilatation, but to feel for the head of the baby" (Jepson/MacDonald 1988).

2.2.3.1c *Coaching the woman in labour*
Women in labour may be encouraged to *walk around during early labour* by TBAs in Kenya [Akamba people], Nigeria [Annang people], South Africa [Zulu; Xhosa people], Zambia [Tonga people] and Zimbabwe [Shona people] (Baartman 1983; Brink 1982; van Ginneken et al. 1984 in Rebel 1988; Larsen et al.1983a; Le Nobel 1969; Mutambirwa 1985; Rebel 1988). Different arguments for this practice are given: either to stimulate the contractions or to relax the parturient woman in order to stimulate the descent of the fetus into the birth canal.

In Zambia the woman in labour is allowed to walk around till the membranes are ruptured (Le Nobel 1969).

Herbal medicines are given to the woman in labour in the first stage of the delivery in Kenya [Digo people], Malawi, Nigeria [Hausa people], Sierra Leone [Mende people], South Africa [Zulu; Xhosa people], Tanzania [Wahehe; Wagogo; Waluguru; Wanyakyusa; Wachaga and Bahaya people], Zambia [Tonga; Lozi; Mbunda people] and Zimbabwe [Shona people] (Brindley 1985; Bullough/Leary 1982; Gumede 1978; Fleischer 1990; Ityavyar 1984; Jepson/ MacDonald 1988; Larsen et al. 1983a; Le Nobel 1969; MacCormack 1982; Moller 1961; Mutambirwa 1985; Mutambirwa 1985 in Chalmers 1990; Solomon/Rogo 1989; Tyrrell & Jurgens 1983; West 1981; van Zanden 1988). For example Fleischer(1990) reports from Nigeria [Hausa people] that at the beginning of the first strong contractions a plant called "Hanun binta" (Rose of Jericho) is placed in a bowl of water in which it will swell. The parturient woman then has to drink regularly from this water as it is believed to cause an easy delivery. TBAs of the Zulu in South Africa (Kwa Mboma district) advise the women to drink tea during the course of the first stage (Jepson/MacDonald 1988).
The herbal medicines (which may be administered orally, applied vaginally or rubbed into the skin of the abdomen) and their purposes are summarized in Table 2.2.3.1c.
Most of these medicines are administered orally; 'Loada' (scientific name unknown) in Nigeria and 'Musikili' (Trichilia emetica) in Zambia are placed into the vagina and 'Chigara' (Acacia senensis), 'Palibekanthu' (Dicoma-kirkii) and 'Mgundumula' (Triumfetta tomentosa) in Malawi are rubbed into the skin of the abdomen.

TBAs in South Africa [Zulu people] may *advise the woman in labour to push* either as soon as the first labour pains are felt or when the contractions become strong, but they may also wait until the woman is perspiring heavily (Jepson/MacDonald 1988).

TBAs *massage and press on the woman's abdomen* according to reports from Ghana [Ga people], Kenya [Akamba people], Nigeria [Annang people] and South Africa [Zulu people] (Brink 1982; Jepson/MacDonald 1988; Kuntner 1988; Otoo 1973; Rebel 1988). Some TBAs of the Zulu don't apply fundal pressure at all, others always do as they feel "that fundal pressure should be applied, either when the woman becomes restless, or when she actually feels ready to push" (Jepson/ MacDonald 1988). In addition to the massaging and pressuring the woman's abdomen sometimes a piece of cloth (or a cord) is tied around the upper part of the abdomen, as has been reported from South Africa [Zulu; Xhosa people] and Zambia [Lozi; Mbunda people] (Baartman 1983; Brindley 1982;1985 in Chalmers 1990; Jepson/MacDonald 1988; Kuntner 1988; van Zanden 1988). Jepson/ MacDonald (1988) indicate that tying a cord around the woman's abdomen is performed "to prevent the uterus relaxing back to its former position after each contraction". Sometimes the abdominal skin is rubbed with warm water (in Kenya [Akamba people]; Rebel 1988), a herbal infusion or an ash/water mixture, (in

Table 2.2.3.1c Herbal medicines used by TBAs in Africa in the first stage of delivery

Country	People	Vernacular name of herb (if known, scientific name in brackets)	Purpose
Malawi		'Chigara' (Acacia senensis)	may hasten delivery
		'Mgundumula' (Triumfetta tomentosa)	"
		'Nthundza' (Flacourtia indica)	may induce labour when overdue or may be used to turn fetus to correct presentation
		'Mtsatule' (Allophylus africanus, A. Chaunostachys)	may promote the dilatation of the cervix
		'Mfulatira' (Boscia salicifolia)	may promote better contractions
		'Futsa' (Veronia adoensis, V. amygdalina, V. glabra)	"
		'Chilambe' (Cissampelos Mucronata)	may cause good fetal growth, an easy labour and a short third stage of labour
		'Palibekanthu' (Dicoma-kirkii)	may improve contractions, and hasten delivery
		'Chewe' (Sesasum angolense)	may cause good fetal growth, an easy labour and a quick delivery of the placenta
Nigeria	Hausa	'Loada'	makes the birth canal moist and slippery in order to encourage the descent of the fetus
		'Hanun binta' {also known as 'Rose of Jericho'}	may cause an easy delivery
Sierra Leone	Mende	'Impeery' (Limba)	may induce and increase labour pains; quickens contractions
		'Arrata' {also known as 'Never-die or Mouse-ears'}	may induce labour and/or stimulate contractions
		'Boogbandi' (Carica papaya)	"
		'Kosit' (Tetracera alnifolia)	may induce labour
		Medicine made from crushing? (Ficus exasperata) and? (Carica papaya)	may stimulate contractions
South Africa	Zulu;Xhosa	'Masumo'	may enhance labour
		'Inembe'	"
		'Isihlambeso'	"
		'Imbelekisane'	"
Tanzania	Bahaya	'Enshamba'	may stimulate contractions
Zambia	Tonga	'Musikili' (Trichilia emetica)	may promote the dilatation of the cervix
	Lozi; Mbunda	? (Ficus Sycomorus)	may cause strong contractions

Sources: Bullough/Leary 1982; Chalmers 1990; Ityavyar 1984; Jepson/MacDonald 1988; Le Nobel 1969; MacCormack 1982; Moller 1961; Solomon/Rogo 1989; West 1981; van Zanden 1988

South Africa [Zulu people]; Jepson/MacDonald 1988), or with pig's fat (in Zambia [Tonga people]; Le Nobel 1969).
Van Zanden (1988) reports from Zambia [Lozi; Mbunda people] that in case of weak contractions the abdomen is rubbed with a powder made of leaves.

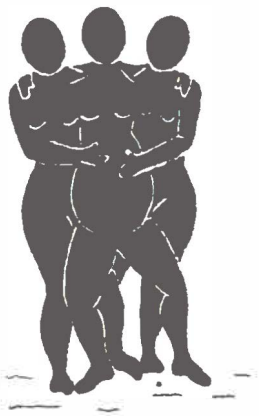
Whether a woman is allowed to *scream during labour* or not, is culturally related. Not much information about this from different cultures in Africa could be traced; only from Sierra Leone [Mende people] and South Africa [Zulu; Xhosa people] (Chalmers 1990; Kuntner 1988; West 1981) where it has been reported that TBAs do not allow a parturient woman to make any noise. West (1981) states that only primigravidas are "strongly coached in how to control their noise level by making very high pitched sounds and snapping their fingers at the peak of the contractions". It is argued that: "If the women will cry out, the TBAs fear that the husbands might become angry and accuse them of malpractice or 'bad magic'."
Kuntner (1988) reports also that in case the woman will shout the TBA will immediately close the woman's mouth with her hand in order to prevent men hearing what is going on. Chalmers (1990) states that "crying out in labour reflects poorly on the woman's family's preparation for childbirth".

Mapondera (1989) reports from Zimbabwe that "the *perineum* is prevented from tearing during the second stage by *massage with herbs* from time to time throughout the first stage of labour".

2.2.3.2 SECOND STAGE

2.2.3.2a *Position of the mother*

An *upright position* either kneeling, sitting, squatting or standing is the most common position for delivery in Ghana [Ga people], Kenya [Akamba; Digo people], Nigeria [Annang; Hausa people], Sierra Leone [Mende people], South Africa [Zulu; Xhosa people], Sudan, Tanzania [Waluguru; Wanyakyusa people], Zambia [Tonga; Lozi; Mbunda people] and Zimbabwe [Shona people] (Baartman 1983; Brindley 1982/1985; Brink 1982; Buchmann et al.1989; El Hakim,1981; Fleischer 1990; van Ginneken et al.1984 in Rebel 1988; Gumede 1978; Ityavyar 1984; Jepson/MacDonald 1988; Kuntner 1988; Larsen et al. 1983a; Le Nobel 1969; MacCormack 1982; Moller 1961; Mutambirwa 1985; Otoo 1973; Rebel 1988; Solomon/Rogo 1989; West 1981; van Zanden 1988). In addition women in labour in Kenya, South Africa and Sudan may at the same time support themselves by a rope which is attached to the ceiling of the room.
Mothers in Kenya [Digo people] may deliver sitting "on the seated TBAs lap with the legs partly abducted to allow the passage of the baby" (TBAs "find no discomfort in this arrangement so long as the mother is of moderate weight and second stage is not prolonged; this position is preferred by many parturients.") (Solomon/Rogo 1989).



standing

kneeling

squatting

sitting

upright position

A *(semi)recumbent position* has been reported from Tanzania [Wahehe; Wagogo people] (Moller 1961); van Zanden (1988) reports from Zambia [Lozi; Mbunda people] that a lying position is allowed only for the first delivery. Some TBAs in South Africa [Zulu people] appear to prefer the use of a lithotomy position (Jepson/MacDonald 1988).

recumbent position

2.2.3.2b *Preparation of the birth canal/Support of the perineum*
In several reports from different countries of Africa it is mentioned that TBAs try to minimize laceration of the perineum. E.g. TBAs of the Mende people in Sierra Leone may *lubricate the rim of the birth canal with palm oil* in an attempt to minimize laceration of the anterior vagina, a special risk for circumcised women

(West 1981). MacCormack (1982) reports also from the Mende people in Sierra Leone that in the second stage of labour the TBA sits facing the labouring woman, "*supporting the perineum with her toe* while the woman is pushing". In South Africa [Zulu; Xhosa people] it is the woman in labour who is supporting the perineum: "Birth takes place in a kneeling position with the woman's knees spread apart and her heels together, supporting her perineum." (Chalmers 1990). In Nigeria [Annang people] TBAs may "assist during delivery placing the woman in a *supported squatting position which stretches the perineum* and reduces tearing" (Brink 1982).

2.2.3.3 THIRD STAGE

2.2.3.3a *Birth of the placenta*

From Zambia [Tonga people] (Le Nobel 1969) it has been notified that "immediately after birth the baby is put aside the mother, as far as the lenght of the cord permits. Initially *the TBA waits* patiently, while the woman has to push." If the placenta has not been expelled after a couple of hours, the TBA initiates active management [see 2.2.4.3a]. In Sierra Leone [Mende people] (West 1981) TBAs will wait up till one hour before taking action. TBAs in Benin [Bariba people] do not wait as long as the TBAs in Zambia or Sierra Leone: they believe that the placenta is part of the infant, and for that reason they consider it necessary that the two should be delivered together. If the mother delivers the baby and the placenta does not follow within five or ten minutes, remedial action has to be started (Sargent 1982).

Ordering the mother to push to stimulate the birth of the placenta has been reported from Kenya [Akamba people] en Zambia [Tonga people] (Le Nobel 1969; Rebel 1988). Making the mother *chew on leather* is another method, performed in Kenya [Akamba people] (Voorhoeve A. 1979). *Massage, pressing or rubbing the mother's abdomen* has been indicated from Egypt and Kenya [Akamba people] (van Ginneken et al. 1984 in Rebel 1988; Most van Spijk 1982; Rebel 1988; Voorhoeve A. 1979). In Ghana [Ga people] and South Africa [Zulu people] (Kuntner 1988; Otoo 1973) TBAs may ask the mother to *blow energetically into a bottle.* Brink (1982) observed a delivery in Nigeria [Annang people]: "At 9.15 a.m. the baby's head was born face down and the TBA helped the baby out by pulling out one arm, then the other and twisting the body gently until finally the buttocks and legs were free. It was a boy. She laid him down on the ground beside her and reached up to *pull at the placenta.* She pulled and manipulated until finally the placenta was delivered."

2.2.4 The intrapartum period *(pathological)*

2.2.4.1 FIRST STAGE

2.2.4.1a *Prolonged labour*

In cases of prolonged labour *herbs* are given in Ghana [Asante; Fanti; Ga people], Nigeria [Hausa people], Sierra Leone [Mende people], South Africa [Zulu people] and Tanzania [Wahehe; Wagogo people] (Ityavyar 1984; Jepson/MacDonald 1988; Kaye 1962; Larsen et al.1983a; Moller 1961; Otoo 1973; West 1981). These herbs are administered *orally.* Larsen et al.(1983a) describe treatment with 'Imbelekisane':

this is a liquid made by soaking roots and herbs, or the bladder or uterus of a monkey in (usually hot) water. West (1981) reports the use of 'Arrata' [also known as 'Never-die' or 'Mouse-ear' leaves], Otoo (1973) states that a TBA "might administer some concoction containing okra noted for its sliminess" and Jepson/ MacDonald (1988) indicate that TBAs prepare a liquid made by soaking the leaves of the 'Ikonono' bush in water. Herbs can also be *smeared on the abdomen and vulva or put into the vagina* of the woman in labour as has been reported from Ghana [Ga people], Nigeria [Ife people] and Tanzania [Wagogo people] (Lawson/ Stewart 1970; Moller 1961; Otoo 1973). "A lump of crushed herbs of various kinds (tobacco-leaves and others) is pushed up into the vagina" (Moller 1961). In addition other devices are used in cases of prolonged labour: "*purges, ointments or blowing into an empty bottle*" in Ghana [Ga people] (Kaye 1962), "an *object may be stuck in the woman's mouth* to encourage her to cough the baby out" in Sierra Leone [Mende people] (MacCormack 1982), *massage of the abdomen* or *fundal pressure* is performed in Kenya [Akamba people] and Sierra Leone [Mende people] (van Ginneken et al. 1984 in Rebel 1988; MacCormack 1982). TBAs in Ghana [Ga people] are "*brushing* over the woman in labour *with a broom to sweep off any evil*" (Otoo 1973).

TBAs may *stretch the vagina* with the hands in Ghana [Ga people], Kenya [Akamba people], Sierra Leone [Mende people] and Tanzania [Wachaga people] (van Ginneken et al. 1984 in Rebel 1988; Kaye 1962; MacCormack 1982; Moller 1961). In addition TBAs try to enlarge the introitus of the vagina by *incision* with a sharp edged reed, a blade, knife or piece of glass according to reports from Nigeria [Hausa people], South Africa [Zulu people] and Zambia [Lozi; Mbunda people] (Brindley 1985; Ityavyar 1984; Kuntner 1988; Mphlange 1985 in Chalmers 1990; van Zanden 1988), or by "*applying ash* on places where the skin is stretched in order *to make the skin tear*" as has been reported from Kenya [Akamba people] (Rebel 1988). Ityavyar (1984) notes that "a TBA cuts the woman's labia minora to deliver the baby". In Nigeria [Hausa people] the practice of cutting a pregnant mother by a TBA to deliver a baby is known as 'gishiri cut'. The 'gishiri cut' is done only after all other possible avenues of normal delivery have been tried in vain."

In South Africa [Zulu people] an *internal version* of the fetus may be attempted by experienced TBAs (Brindley 1985 in Chalmers 1990; Gumede 1978).

In many places 'obstructed' (=prolonged) labour is attributed to the woman's infidelity to her husband: for that reason a woman in labour may be forced to *confess unfaithfulness* to her husband in order to clear the obstruction in Ghana [Ga; Asante people], Senegal [Diola people], Sierra Leone [Mende people], South Africa [Zulu; Xhosa people], Tanzania [Beha people], Zambia [Tonga people] and Zimbabwe (Brindley 1985; Gelfand 1980; Kaye 1962; Korfker 1983; Le Nobel 1969; MacCormack 1982; Mapondera 1989; Mutambirwa 1985; Otoo 1973; Price & Lachman 1978; as reviewed by Statius van Eps 1954; Tyrrell & Jurgens 1985 in Chalmers 1990). It is the task of the TBAs to obtain this confession by persuading the woman in labour. Chalmers (1990) states that confessing means "opening her heart which is believed to result in her body following suit". In addition it has been reported from Zambia [Lozi; Mbunda people] (van der Lans/Nooter 1988; van Zanden 1988) that prolonged labour is attributed to

infidelity of the husband of the woman in labour. In this case it is the husband who has to confess unfaithfulness.
TBAs in South Africa [Zulu people] believe that the causes of a prolonged labour could be a poor relationship with the ancestors (='umeqo'), a tight perineum, a contracted pelvis or placenta praevia (Larsen et al. 1983a).

2.2.4.2 SECOND STAGE

2.2.4.2a *Management breech presentation*

From Kenya [Akamba people] (van Ginneken et al. 1984 in Rebel 1988) it has been reported that in cases of a wrong position the TBA "will try to *turn it through the birth canal* and other people can be asked to *hold the woman upside down*". Rebel(1988) reports about special methods used to manage a breech presentation: "*the trunk is held* until the head is born, the woman is ordered to push to speed up the birth of the head or the *child's head is slowly pulled*, the perineal skin is removed from the child's face and the child's mouth is cleaned as soon as possible".
Kuntner (1988) has indicated that sometimes TBAs of the Zulu may perform an *episiotomy* with a very sharp blade of grass, piece of glass or knife in cases of a breech presentation.
With breech presentation in Sierra Leone [Mende people] TBAs may "*lubricate the perineal skin with palm oil and lift up the legs of the baby* towards the mother. If this fails they pull with force." (MacCormack 1982)

2.2.4.3 THIRD STAGE

2.2.4.3a *Retained placenta*

In cases of a retained placenta a number of therapeutic methods are administered by TBAs. *Abdominal massage and fundal pressure* (while sometimes the woman is given a liquid made of herbs to drink) are performed by TBAs in Kenya [Akamba people], Senegal [Diola people], Sierra Leone [Mende people], Zambia [Tonga people] and Zimbabwe [Shona people] (van Ginneken et al. 1984 in Rebel 1988; Korfker 1983; Mutambirwa 1985; Le Nobel 1969; West 1981). *Manual removal of the placenta* is tried by TBAs in Kenya [Akamba people], Nigeria [Edo people], Sierra Leone [Mende people], South Africa [Zulu; Xhosa people], Tanzania [Wagogo; Waluguru; Wanyakyusa people] and Zambia [Tonga; Lozi; Mbunda people] (Akenzua et al. 1981; Baartman 1983; Brindley 1985 in Chalmers 1990; Jepson/MacDonald 1988; Larsen et al. 1983a; Le Nobel 1969; Moller 1961; Voorhoeve A. 1979; West 1981; van Zanden 1988). Baartman (1983) and Brindley (1985) have stated, though, that a manual removal is only attempted by the bravest TBAs. At times manual removal is exerted after abdominal massage and fundal pressure as West (1981) describes: "If the placenta is retained beyond an hour, abdominal massage and fundal pressure will be exerted. If placental expulsion does not occur, the cord will be cut and an axe will be tied to the end of the cord. The rope or coiled piece of cloth which was tied around the mother's waist immediately after delivery in order to keep the placenta from suffocating her by rising into the chest cavity, will be tightened. Manual removal may be attempted by the TBA, or the mother may be taken either to another indigenous practitioner with more magical skills or to the hospital." Le Nobel (1969) notes that "the TBA

starts to massage the woman's abdomen in a forceful way. External expression is practised, whether or not pains occur. The TBA pulls the cord and tries to remove the placenta by hand." Referring to manual removal exerted by the TBAs of the Wanyakyusa Moller (1961) remarks: "The only complication the TBA can sometimes deal with successfully is a retained placenta, where manual removal is sometimes done. The TBAs are well aware of the danger of pulling the cord or membranes and this is carefully avoided."

In cases of a retained placenta TBAs may also give *herbs* to the mother which have to be taken *orally* according to reports from Benin [Bariba people], Kenya [Akamba; Digo people], Malawi, Nigeria [Edo people], Senegal [Diola people] and Zimbabwe [Shona people] (Akenzua et al.1981; Bullough/ Leary 1982; van Ginneken et al.1984 in Rebel 1988; Korfker 1983; Mutambirwa 1985; Sargent 1982; Solomon/Rogo 1989). TBAs in Malawi, for example, may give 'Mtanthanyerere' ('Asparagus sp.')(Bullough/Leary 1982).

In Nigeria [Hausa people] TBAs may use one of four different therapeutic methods:

a *broom method* – "a new broom is placed in the lower abdomen of the woman while she is still in the squatting or kneeling position. The TBA pulls the abdomen towards the diaphragm with the aid of the broom. The TBA then removes the broom and allows the abdomen to fall back suddenly, helping to expel the placenta."

b *gourd method* – the woman is given a gourd to inflate. Inflation of the gourd may induce a retch reflex, which will increase the abdominal pressure helping to expel the placenta.

c *vomiting method* – a wooden spatula is inserted into the woman's mouth. "It is carefully pushed deep down the throat to cause the woman to vomit. The movement of the body and the strains the woman experiences on the abdomen helps to expel the placenta."

d *sneezing method* – "bitter pepper called 'borkomo' is poured into a fire near the woman in labour. The woman sneezes as the strong smell from the burning pepper reaches her. According to the TBAs the placenta is expelled as the woman continues to sneeze vigorously." (Ityavyar 1984)

The broom method has also been reported from Benin [Bariba people] by Sargent (1982) describing the method as "rolling the abdomen of the woman in labour with a broom or other object" (see also 2.4.4.3a).

The gourd method is also used by TBAs of the Zulu and Xhosa people in South Africa (Baartman 1983; Gumede 1978; Jepson/MacDonald 1988; Larsen et al. 1983a). In addition TBAs in Kenya [Akamba people] use a similar therapeutic method: they "tell the woman to blow on something to increase the intra-abdominal pressure" (Rebel 1988)(see also 2.4.4.3a).

The vomiting method is also administered in Benin [Bariba people], Kenya [Akamba people], South Africa [Zulu people], Zambia [Tonga people] and Zimbabwe (van Ginneken et al.1984 in Rebel 1988; Larsen et al. 1983a; Le Nobel 1969; Mapondera 1989; Mutambirwa 1985; Rebel 1988; Sargent 1982). The method is exerted in different ways like "giving a large volume of water to drink", "tickling the back of the woman's mouth", "a wooden spoon on the woman's

tongue", "sticking a feather down the throat of the woman in labour or gagging her with a porridge-stick" or "inserting a short twig into the throat" (see also 2.3.4.3a/2.4.4.3a).
The sneezing method is also mentioned by Baartman (1983 in Chalmers 1990) from South Africa [Xhosa people], by Le Nobel(1969) from Zambia [Tonga people] and by Mutambirwa (1985) from Zimbabwe [Shona people]. Administering medicines by fumigation as has been reported from Benin [Bariba people] by Sargent (1982) may refer to the sneezing method and/or a ritual procedure.

2.2.4.3b *Postpartum haemorrhage*
Le Nobel (1969) reports from Zambia [Tonga people]: "Post-partum haemorrhage is treated by *inserting special herbs into the vagina.* The herbs swell and compress the blood vessels. In the mean time some cloths are soaked in a basin of hot water; the cloths are wrung out and are tied around the lower abdomen in order to decrease the size of the uterus."
TBAs in South Africa [Zulu people] (Kwa Bangiswe district) give the mother a liquid made by soaking 'Lala' palm roots and mixed herbs in water to reduce the risk of a postpartum haemorrhage. In addition it has been stated that the TBAs "were unable to estimate the amount of blood loss associated with a normal delivery, but all felt that a moderate blood loss was necessary to reduce the risk of severe after-birth pains. However, if the mother started to feel weak, then they thought that she was probably losing too much blood. They would first try administering a herbal infusion* (called 'Ngazini' by TBAs of the Mseleni district), ... but they would call for an ambulance if bleeding continued to be excessive." The TBAs "were unable to state any causes of postpartum haemorrhage, but they all considered that a pregnant woman had too much blood, some of which needed to be lost after the birth. Others thought that this was 'bad' (menstrual; YL) blood as it had not been evacuated for 9 months. Several believed that a woman was more likely to bleed heavily if she usually suffered from dysmenorrhoea." (Jepson/MacDonald 1988) Similar to the study in Kwa Bangiswe district in South Africa TBAs in Sierra Leone [Mende people] believe that postpartum haemorrhage "provides an explanation for the lack of menstrual flow during pregnancy and is seen as cleansing the woman of a build up of 'bad blood'." Due to this belief postpartum haemorrhage is not thought to be alarming. Therefore active management is not initiated by TBAs. From Benin [Bariba people] and South Africa [Zulu people] (Larsen et al.1983a; Sargent 1982) it has also reported that TBAs don't recognize postpartum haemorrhage as a serious complication as they believe that if the blood loss is excessive it is because the 'mother has too much blood in her' and that the correct procedure is to allow it to flow (see also 2.3.4.3b).

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* Infusion: see footnote pg. 15.

2.2.5 The postnatal period *(physiological)*

2.2.5.1 CUTTING OF THE UMBILICAL CORD

Here we describe successively: *how, at what distance from the umbilicus* and *when* TBAs cut the umbilical cord.

2.2.5.1a *How do TBAs cut the umbilical cord?*

TBAs cut the umbilical cord with different kinds of *sharp tools* like a piece of glass, a blade of grass, razor blade, knife, scissors, etc.: all these 'instruments' used by TBAs in different countries of Africa are summarized in Table 2.2.5.1a.

West (1981) reports from Sierra Leone [Mende people] that "generally the instrument used to cut the umbilical cord will be cleaned with a piece of cloth, or rinsed in warm or hot water, but is rarely sufficiently sterilized". Brink (1982) observed in Nigeria [Annang people] that the TBA "brought a new razor blade which she removed from its paper wrapping; she rinsed the razor blade off in a pot of water."TBAs in Kenya [Digo people] use knives or razor blades which are neither new nor sterile (Solomon/Rogo 1989). The name of the leaf used as cutting tool in Sierra Leone [Mende people] is 'Cyperus rotundus' (MacCormack 1982). In Tanzania [Bahaya people] razor-sharp strips of the stem of the elephant grass 'Pennisetum purpureum' are used (Moller 1961).

2.2.5.1b *At what distance from the umbilicus do TBAs cut the cord?*

The umbilical cord is *left long* in Malagasy [Tanala people], Nigeria [Annang people], Sierra Leone [Mende people], South Africa [Zulu people], Tanzania [Bena; Wahehe; Wagogo people] and Zambia [Tonga people] (Brink 1982; Jepson/MacDonald 1988; Kuntner 1988; Moller 1961; Le Nobel 1969; West 1981). Le Nobel(1969) states that the cord "is cut at the distance from umbilicus till the knee of the infant", while West (1981) indicates that it is cut about 7,5 cm from the umbilicus. Brink (1982) observed the TBA "carefully pulling the umbilical cord from the baby up between his legs to the middle of his back; she marked that spot and after squeezing (milking) the blood from the placenta to the baby, cut the cord at the place she marked." Jepson/MacDonald (1988) indicate that prior to cutting a piece of string or fibre is tied at a distance of one thumb-length from the belly. Kuntner (1988) has noted that the TBA stretches the cord along the leg of the child, ties it in two places (one over and one under the knee), and cuts in between.

Voorhoeve (personal communication,1991) indicated that the TBA of the Yoruba people in Nigeria carefully pulls the cord from the infant either upwards to the shoulder where she cuts the cord or downwards passing the knee. In both cases it is strictly avoided to pass the genitals as it is believed that the child might become infertile (see also 2.3.5.1b). The TBA of the Bena (Tanzania) attaches the cord stump to the arm of the infant and the TBA of the Tanala (Malagasy) attaches it to the neck of the infant as it is believed that this accelerates the dropping of the cord (Kuntner,1988); TBAs of the Wahehe and Wagogo (Tanzania) may tie the cord with a long string which is tied in a loop round the neck of the infant "so that the stump of the cord is pulled upwards" [in order to avoid umbilical hernia?; YL] (Moller 1961).

Table 2.2.5.1a Instruments to cut the umbilical cord used by TBAs in different countries of Africa

Country	People	Instrument
Egypt		handle of a needle to be used for a primus stove
Ghana	Ga	knife
Kenya	Digo	
Nigeria	Yoruba	
Sierra Leone	Mende	
Tanzania	Waluguru; Wanyakyusa	
Zambia	Lozi; Mbunda	
Ghana	Ga	razor blade
Kenya	Akamba; Digo	
Nigeria	Hausa; Yoruba; Edo; Annang	
Sierra Leone	Mende	
South Africa	Zulu	
Tanzania	Wanyakyusa	
Zambia	Lozi; Mbunda	
Ghana	Ga	scissors
Sierra Leone	Mende	
South Africa	Zulu	
Tanzania	Wanyakyusa	
Ghana	Ga	piece of glass of a broken bottle
Nigeria	Yoruba	
Nigeria	Hausa; Edo	grass, reed, corn or (edge of) raffia stalk
South Africa	Zulu	
Tanzania	Wahehe; Wagogo; Bahaya	
Zambia	Lozi; Mbunda	
Zimbabwe	Shona	
Nigeria	Yoruba	sliver of bamboo
Sierra Leone	Mende	edge of a leaf
Tanzania	Wagogo	
Zambia	Lozi; Mbunda	
Zambia	Tonga	tail-hairs of a cow

Sources: Akenzua et al. 1981; Brink 1982; Buchmann et al. 1989; van Ginneken 1984 in Rebel 1988; Hilton 1983; Jepson/MacDonald 1988; Kuntner 1988; Larsen et al. 1983a; Le Nobel 1969; MacCormack 1982; Maclean 1982 in Oudesluys-Murphy 1990; Moller 1961; Most van Spijk 1982; Mutambirwa 1985; Otoo 1973; Solomon/Rogo 1989; Wes, 1981; van Zanden 1988

2.2.5.1c *When do TBAs cut the umbilical cord?*

TBAs usually cut the umbilical cord *after the birth of the placenta* as has been reported from Egypt, Kenya [Akamba; Digo people], Nigeria [Annang; Hausa people], Sierra Leone [Mende people], South Africa [Zulu; Xhosa people], Tanzania [Wahehe people], Zambia [Tonga; Lozi; Mbunda people] and Zimbabwe

[Shona people] (Baartman 1983; Brink 1982; van Ginneken 1984 in Rebel 1988; Ityavyar 1984; Jepson/MacDonald 1988; Kuntner 1988; Le Nobel 1969; Lewis 1983 in Chalmers 1990; MacCormack 1982; Moller 1961; Most van Spijk 1982; Mutambirwa 1985; Solomon/Rogo 1989; West 1981; van Zanden 1988). Jepson/MacDonald (1988) indicate from South Africa [Zulu people] that "the cord was not usually cut until the placenta had been delivered, and blood was milked away from the baby towards the placenta." No explanation is given why the blood is milked *away* from the baby *towards* the placenta. Usually 'milking of the cord' is executed in order to squeeze the blood towards the baby (as mentioned above; see also 2.2.6.1 and 2.3.6.1). [In only one study – from Asia – it was indicated that part of the blood in the umbilical cord is milked towards the mother (see 2.3.5.1c)]. In Otoo's study of TBAs in Ghana [Ga people] (1973) cutting of the cord was not related to the birth of the placenta but "the cord was cut when *the baby cried. If the baby did not cry, the cord was milked.*" [see also 2.2.6.1]
TBAs of the Zulu in South Africa cut the cord *once it has stopped pulsating* (Brindley 1985 in Chalmers 1990; Gumede 1978; Larsen et al. 1983a).

2.2.5.2 Dressing of the umbilical cord

TBAs may dress the umbilical cord with any of the following: *dung, mashed leaves, ashes, soot, salt etc.* The dressings used by TBAs in Africa are summarized in Table 2.2.5.2.
West (1981) and MacCormack (1982) report from Sierra Leone[Mende people] that the names of the mashed leaves are: 'Arrata' or 'Bryophyllum pinnatum' [= 'never-die-leaf'] or 'Nicotiana tabacum' [tobacco leaf], of the cola nuts: 'Cola nitida' and of the spice which is ground with a few drops of water: 'Xylopia aethiopica'. In addition it is mentioned that all the 'medicines' are applied to the stump, which is then wrapped with a strip of rag. This is renewed regularly until the stump separates. Moller (1961) reports from Tanzania [Wahehe people]: "The stump is treated with so-called Ugogo salt or rock salt and a few drops of the milk-juice from an euphorbia-plant. (..) It is said that the euphorbia juice makes the cord drop off quicker than normal*, within 2-3 days." In addition Moller indicates that the local names of the castor oil used by the TBAs of the Waluguru are: 'Mafuta ya mbalika' and 'Nyembe', while the name of the roots used by the TBAs of the Wanyakyusa is 'Njere'.
The Yoruba people in Nigeria apply a piece of heated stone or potshead wrapped in a wet cloth to the umbilicus after they have dressed it with the ashes from the parent's burnt sleeping mat (Maclean 1982 in Oudesluys-Murphy 1990).
TBAs in South Africa [Zulu people] (in Kwa Mboma and Mseleni district) *do not apply any medication* to the cord stump unless it fails to heal. In that case they may

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* It is difficult to say what is 'normal'. It has been indicated that most mothers are aware that the stump of the umbilical cord separates within a period of approximately 10 days after delivery. In most standard textbooks it is stated that it separates during the first one to two weeks after birth. However, there seems to be not much known of the time at which separation occurs as it has received very little attention in the medical literature until now (Oudesluys-Murphy 1990).

Table 2.2.5.2 Dressings of the umbilical cord used by TBAs in Africa

Country	People	Dressing
Benin Sierra Leone Zimbabwe	unknown Mende Shona	dung (of cow, chicken, rat)
Egypt	unknown	powder obtained by grinding of an aspirine
Kenya	Digo	ashes, or nothing
Liberia	unknown	ground herbs; sap of unripe paw paw; everlasting leaf; dust from floor; clay; alcohol; red palm oil
Morocco	unknown	henna or kohl
Nigeria Sierra Leone South Africa Tanzania Zambia Zimbabwe	Yoruba Mende Zulu; Xhosa Wahehe; Wagogo Tonga Shona	ashes or mixture of ashes with salt; soot; earth; powder made from roots
Sierra Leone	Mende	spittle from chewing a kola nut, tobacco leaf or snuff; talcum powder; petroleum jelly; scrapings from the bottom of a clay drinking-water pot; a spice ['Xylopia aethiopica'] ground with a few drops of water
Sierra Leone Tanzania Zimbabwe	Mende Wagogo; Waluguru; Wanyakyusa	juice from mashed (banana) leaves or roots
South Africa	Zulu	nothing; commercial antiseptics; petroleum jelly; carbon from cooking-pot; red clay
Tanzania	Wahehe	mixture of salt and juice or ashes
Tanzania	Wagogo; Waluguru; Wanyakyusa	mixture of soot and castor-oil
Tanzania	Wachaga	butter

Sources: Baartman 1983; Buchmann et al. 1989; Gumede 1978; Lartson et al. 1987; Le Nobel 1969; MacCormack 1982; Maclean 1982 in Oudesluys-Murphy 1990; Mapondera 1989; Moller 1961; Most van Spijk 1982; Mutambirwa 1985; Oudesluys-Murphy 1990; Solomon/Rogo 1989; Vos 1990; West 1981

use Vaseline, grease or an ash/water mixture while TBAs in the Kwa Bangiswe district may use methylated spirits or an ash/grass mixture ('Idumo') (Jepson/ MacDonald 1988). TBAs of the Zulu in South Africa (Ingwavuma district) usually also don't apply anything to the stump (Buchmann et al. 1989). TBAs of the the Zulu in the Vulamehlo district treat the cord stump "with various traditional remedies to help it dry out quickly" (Larsen et al 1983a).

2.2.5.3 Care of the infant

TBAs may *clean the mouth of the infant* immediately after birth with their finger or a piece of cloth according to reports from Ghana [Asante people], South Africa [Zulu people] and Zimbabwe [Shona people] (Brindley 1985 in Chalmers 1990; Gumede 1978; Kaye 1962; Kuntner 1988; Mutambirwa 1985), while TBAs in Sierra Leone [Mende people] (West 1981) *suck the mucus out* from the infant's mouth and nose by mouth. TBAs in Nigeria [Edo people] generally wipe off secretions from the nose and mouth of the newborn while some of them suck out such secretions by mouth (Akenzua et al. 1981).

Sneezing is induced by TBAs of the Zulu in South Africa to expel bad spirits (Brindley 1985 in Chalmers 1990); in addition the infant may be *'smoked'* ['a widespread practice'] "by being passed through the fumes rising from burning medicinal herbs in order to exorcize evil spirits" (Brindley 1985 in Chalmers 1990; Gumede 1978; Krige 1957; Tyrrell & Jurgens 1983).

In Egypt Most van Spijk (1982) observed a TBA "smearing some blood in the child's mouth to learn how to swallow". (In addition it has been noted that "for the rest, the infant is getting as little attention as possible for fear of the evil spirits"). TBAs in Ghana [Adangme; Asante people] may *"clear the infant's throat* by giving it a few drops of gin, rum or lime juice" (Kaye 1962).

In many places of Africa – Ghana [Adangme; Akwapim; Asante; Ga; Tallensi; Ewe people], Kenya [Akamba people], Nigeria [Annang; Hausa people], Sierra Leone [Mende people], South Africa [Zulu people], Tanzania [Wahehe people] and Zambia [Tonga people] – the infant is *bathed*, but there is variation in when and how this is performed (Brink 1982; Ityavyar 1984; Kaye 1962; Larsen et al. 1983a; Le Nobel 1969; Moller 1961; Rebel 1988; West 1981). In Nigeria the infant of the Annang people is bathed after it has been cleaned off with very fine sand obtained by grinding a piece of mud from the wall of the hut: the TBA "picked up the baby, and carried him over to the new fine sand that had been prepared for him. Sitting on her stool near the sand she held the baby in her lap and carefully cleaned him off with the sand, starting at the hair and face and working down over his body" (Brink 1982). In Zambia the infant "is not washed until the stump of the cord has come off" (Le Nobel 1969).

Bathing is performed with cold water (Kenya [Akamba people], Nigeria [Annang people]),with warm water (South Africa [Zulu people]), with warm herbal water (Ghana [Ga people], Nigeria [Hausa people], Sierra Leone [Mende people]), with soap and soda (Nigeria [Hausa people]), or with a mixture of kerosene and palm-oil (Ghana [Asante people]). Also in Ghana [Adangme; Fante people] great attention is paid to the first bath of the newly-delivered infant "as it is believed that the birth-odour will persist throughout life if not removed on this occasion". Hence, the very first bath of the newborn may be repeated three times (Kaye 1962).

After bathing, the infant is *wrapped in a cloth* (Nigeria [Annang people], Sierra Leone [Mende people]) or smeared with Vaseline, and wrapped in a warm blanket (South Africa [Zulu people]).

In South Africa [Zulu people] the TBA normally visits a woman she has delivered for 8 days. Then she bathes the infant and gives him an enema when she considers this necessary (Larsen et al. 1983a). In Ghana [Ga people] the newborn is kept

indoors for seven days ['like an egg']; immediately after birth "the father's sister is sent to the medium to consult the oracle and find out whether the child has any special wishes that need to be fulfilled, from which family it came and whether any special rites are required. Until she returns, the mother must sit with the unwashed baby in her arms." After this the wishes of the child and any required ritual have to be fulfilled whereupon both the child and the parents are bathed (Priya 1992).
Kaye (1962) has reported from Ghana [Asante people] that "the *limbs of an infant are massaged and stretched* to ensure their strength".
The infant of the Bahaya (Tanzania) is "subjected to '*medications*' from the first day of its life. It is given medicines and preparations for everything under the sun. There is medicine to make the cord drop off, other medicine may protect either against diarrhoea or constipation or hiccups or running eyes. Medicines are also given to ensure that the child develops straight legs or to make certain that the teeth erupt." (Moller 1961)
The infant of the Zulu and the Xhosa (South Africa) is "subjected to *enemas,* often made from a herb ('Isihlambezo'), to encourage the expulsion of meconium" (Brindley 1985; Larsen et al. 1983a/1983b; Schneider 1985 in Chalmers 1990). In addition enemas are used very commonly in the first week of life, if the infant does not pass a stool or if he is suffering from colic (Larsen et al. 1983a). TBAs in Zimbabwe [Shona people] may instill *eyedrops* made from 'Devil's Thorn' leaves [scientific name unknown/YL] for infants who show signs of conjunctivitis (Mutambirwa 1985). In Egypt Most van Spijk (1982) observed that on the third day the TBA makes the eyelids of the infant black with soot (kohl). "She does so with a little stick, after first putting it in an onion and then in the soot. It is supposed to make the eyes nice and big, and let the eye-lashes grow."

2.2.5.4 Care of the mother after delivery

TBAs in Malawi may give *herbal medicines* to the mother in order to "expel retained products, encourage the flow of lochia or to control bleeding". [The vernacular name of the medicine which promotes the flow of lochia is 'Muwawani'. The scientific name is Cassia.] (Bullough/Leary 1982). A liquid (made by soaking herbs into water) called "Ugobho' is given to the mother by TBAs in South Africa [Zulu people] in order to "aid the involution and healing of the uterus" (Larsen et al. 1983a). The Shona mother in Zimbabwe may be given warm medicated 'bumhe' which is said to contract and clean the uterus (Mutambirwa 1985).

In Zambia [Lozi; Mbunda people] (van Zanden 1988) TBAs *don't suture* the (occasional) *perineal tears*: the mother is advised to take a daily bath and afterwards to apply a powder made of "herbs" to the wounds.
TBAs in Zambia [Tonga people] don't treat "the occasional perineal tears; sometimes a mixture of leaves is applied" (Le Nobel 1969). TBAs in South Africa [Zulu people] wash perineal tears regularly with a solution of salt or Dettol in water. "The mother is then instructed to kneel so that her heels press the wound edges together" (Larsen et al. 1983a).

After delivery of the placenta the Shona mother in Zimbabwe is asked to *cross* her *legs and thighs* tightly to prevent air from entering the anus and vagina (Mutambirwa 1985).

In many places of Africa – in Ghana [Ga people], Kenya [Akamba people], Nigeria [Annang; Hausa people], Sudan [Lango people], Zambia [Lozi; Mbunda people] and Zimbabwe – the mother is *bathed* with warm (sometimes herbal) water (Brink 1982; van Ginneken et al.1984 in Rebel 1988; Ityavyar 1984; Kuntner 1988; Mapondera 1989; Otoo 1973; Rebel 1988; van Zanden 1988).

In Egypt Most van Spijk (1982) observed the care of the mother after delivery: "The TBA presses upon the mother's belly to let the blood flow out. She also puts her foot against the uterus, pulling the woman up by her arms. In that way she straightens the uterus, she says, as it has been sagged because of the delivery .... After birth the TBA returns regularly in order to *massage* the woman."
Massage has also been reported from Ghana [Ga people]: the mother is massaged some hours after delivery (Otoo 1973).

A cloth is *tied* around the mother's belly to let it decrease to its original size in Ghana [Ga people], Kenya [Akamba people] and Nigeria [Annang people] (Brink 1982; van Ginneken et al. 1984 in Rebel 1988; Otoo 1973).

The mother is *kept indoors* for at least a few days in Senegal [Diola people], South Africa [Zulu; Xhosa people], Tanzania [Wahehe people], Zambia [Tonga people] and Zimbabwe (Chalmers 1990; Korfker 1983; Kuntner 1988; Le Nobel 1969; Mapondera 1989; Moller 1961). In Malagasy [Tanala people] the mother has to stay indoors for at least 8 days, in Senegal 4 days, in South Africa 6-8 days, in Zambia 6 days and in Zimbabwe "until the cord has dropped". The argument for keeping the mother indoors is that she has to be hidden for fear of visitors having evil thoughts and desires which might harm the newborn. In addition the mother can recover and rest; the period of rest can take several weeks as has been reported from Tanzania [Wachaga; Wazaramo; Ndengerego; Tumbi; Kwere; Pogoro people] and Zambia [Tonga people] (Boersma 1979; Le Nobel 1969; Moller 1961).

TBAs in Malagasy [Tanala people] and in Zambia [Tonga people] (Kuntner 1988) make a fire in the hut where the mother is kept indoors as it is believed that *warmth and smoke* benefit the purging and recovery process of the mother. Smoke is thought to have magical meaning as well. The fire is kept burning all day. The TBAs of the Tanala prepare a bed of grass (in the hut where the delivery took place) on which the mother will rest during eight days with her body slightly and her legs more highly raised.

2.2.5.5 Care of the placenta

The placenta is buried either near the house where the delivery took place or somewhere in the bush or in the fields as has been reported from Nigeria [Annang people], Senegal [Diola people], Sierra Leone [Mende people], South Africa [Zulu; Xhosa people], Tanzania [Waluguru; Wanyakyusa; Wachaga; Bahaya people] and

Zambia [Tonga people] (Baartman 1983; Brindley 1985; Brink 1982; Gumede 1978; Korfker 1983; Kuntner 1988; Moller 1961; Le Nobel 1969; Schneider 1985 in Chalmers 1990; West 1981). But the placenta may also be buried *inside* the house as in Ghana [Ga people] (Otoo 1973), South Africa [Zulu; Xhosa people] (Chalmers 1990; Kuntner 1988); Tanzania [Wahehe; Wagogo; Waluguru people] (Moller 1961) and Zimbabwe (Mapondera 1989). The Wahehe people (Tanzania) bury the placenta "in a corner of the parent's hut with the severed end of the umbilical cord just showing above ground level, because if it is completely buried it is believed that the mother will not give birth again." (Redmayne in Oudesluys-Murphy 1990). Moller(1961) has reported that the Wahehe bury the placenta "in the root-fork of a 'fertile tree' i.e. a tree which bears a rich crop of fruit".
The placenta may be buried in a secret spot in order to avoid bad influence from evil spirits according to reports from South Africa [Zulu; Xhosa people] and Zimbabwe (Baartman 1983; Brindley 1985; Gumede 1978; Kuntner 1988; Mapondera 1989; Schneider 1985 in Chalmers 1990). The Waluguru in Tanzania dig a hole outside the village in which they bury the placenta: "it is considered to be very important that children should not see the placenta, as it is felt that they might get leprosy or some other serious disease, mostly of the skin"; the Wanyakyusa believe that "it is dangerous if a dog eats the placenta, as it may cause disease and misfortune, especially epilepsy" (Moller 1961). From Senegal [Diola people] and Tanzania [Wanyakyusa; Bahaya people] (Korfker 1983; Moller 1961) it has been reported that the placenta has to be buried with the cord upwards: it is believed in both countries that the woman might otherwise become infertile, whereas in Tanzania [Wanyakyusa people] that the child might get fever and convulsions.
As the Bahaya (Tanzania) regard the placenta "as being the 'brother' or the 'dead brother' of the child born" they believe that "it must not be disposed of crudely. In principle it is treated as a corpse; that is it is wrapped up in a piece of brown bark-cloth which is the traditional shroud" (Moller 1961). The Yoruba in Nigeria believe also that the child is physically and supernaturally attached to the placenta and that "there is considerable significance in the way it is disposed of. It can be put in a pot and buried outside the father's house so that in later life the child will look back to it and not neglect the family. Sometimes it is buried near a river so that when it is covered with water during the rainy season it will protect the child from fevers." (Priya 1992)(see also 2.3.5.5/2.4.5.5).
In South Africa [Zulu people] the placenta may also be *sunk* in a river. The Zulu believe that when crabs eat the placenta the child will be legitimate (Kuntner 1988). In Tanzania [Wachaga people] the placenta may be *burnt* (Moller 1961).
In Tanzania [Wagogo people] and Zambia [Tonga people] (Moller 1961; Le Nobel 1969) a small piece of the cord may be dried and hung round the neck of the infant as a charm to protect the infant and bring good luck.

2.2.6 The postnatal period *(pathological)*

2.2.6.1 Immediate care of the asphyxiated newborn

When the child does not breathe after birth TBAs in Africa have several methods of immediate care. A summary of these methods is given in Table 2.2.6.1.

Table 2.2.6.1 Methods of immediate care of the asphyxiated newborn used by TBAs in Africa

Country	People	Method
Ghana Kenya Zambia	Akwapim; Ga Akamba Mbunda	Slapping the buttocks
Ghana South Africa	Asante Zulu	Giving fumes of pepper or the smoke of a burning herb to inhale
Ghana Kenya South Africa Zambia	Akwapim; Cherepon Akamba Zulu Mbunda	Making (a lot of) noise
Ghana	unknown	Rubbing pepper or ginger on the body
Ghana South Africa	Ga Zulu	Milking the umbilical cord from the maternal end towards the newborn
Kenya Sierra Leone Zambia	Akamba Mende Lozi	Blowing air on the face
Kenya Nigeria Sierra Leone South Africa Zambia Zimbabwe	Akamba Hausa; Edo Mende Zulu Lozi Shona	Spitting, splashing or pouring cold water on the body
Kenya Sierra Leone	Akamba Mende	Sucking out mucus from the mouth and nose
Kenya	Akamba	Holding the newborn upside down
Nigeria	Edo	Sprinkling pepper on the body

Sources: Akenzua et al. 1981; van Ginneken et al. 1984 in Rebel 1988; Ityavyar 1984; Kaye 1962; Kuntner 1988; Larsen et al. 1983a; Mutambirwa 1985; Otoo 1973; Rebel 1988; Voorhoeve A. 1979; West 1981; van Zanden 1988

TBAs in Ghana, Kenya, South Africa and Zambia *make* (a lot of) *noise* by either beating a bowl (Ghana [Akwapim; Cherepon people]), two millstones (South Africa [Zulu people]) or two iron sticks (Zambia [Mbunda people]) against each other, or by rattling things (Kenya [Akamba people]).
Otoo (1973) has reported from Ghana [Ga people] that "if the baby does not cry, the *cord is milked* from the maternal end towards the baby 'to bring the baby's soul into it from the mother'" (see also 2.2.5.1c).

2.3 Asia

2.3.1 The antenatal period *(physiological)*

2.3.1.1 PRENATAL CARE

TBAs in Irian Jaya do an *external examination* at the request of a woman who is suspected to be pregnant in order to confirm or reject the pregnancy. Around the eight month of pregnancy the TBAs will do another examination to check the position of the fetus (Voorhoeve 1965). TBAs in Indonesia (in West Sumatra) [Minangkabau people] similarly perform a medical examination whenever a pregnant woman consults them and another examination towards the end of the pregnancy in order to check the position of the fetus (Lam 1991).

From a sample study among 89 TBAs and their clients carried out in the Philippines in1972 it has been reported that the majority of the interviewed TBAs (96%) were consulted for their care during the prenatal period. These TBAs stated "that most mothers consulted them for the first time between the first and seventh months of pregnancy". They indicated that an important part of the prenatal care consisted of *massage of the abdomen* to ensure the proper positioning of the fetus. The majority of the interviewed clients of the TBAs [n=85] stated "that they consulted the TBA during the prenatal period mainly for the massage and the checking of the position of the fetus." (Mangay-Angara 1981)(see also 2.2.1.1). Massage of the abdomen during pregnancy has also been reported from Indonesia and Malaysia (Laderman 1982; Lam 1991; Onvlee 1973 and Forth 1981 in Niehof 1992; van Oosterhout 1993; Priya 1992). TBAs in Indonesia (in West Sumatra) [Minangkabau people] may apply massage to the abdomen *during the first three months of pregnancy* if the unborn child is considered to be misformed (which may happen if the mother is injured, or in case of witchcraft). The massage is applied to "cure" the misformed fetus. In addition during this first period of pregnancy* an abortion may be forced by strong massage of the abdomen [or by herbal drinks]. *After the first three months of pregnancy* massage of the abdomen may be applied if the pregnant woman is in pain: the TBA applies massage "to the whole belly downwards, but only on the sides. Then the upper legs are massaged, both when the woman is lying on her back, and when the woman sits up, so the TBA can massage her back if necessary." If *towards the end of the pregnancy* the TBA may think the position is wrong or uncomfortable again massage of the abdomen will be applied. The TBA "uses a piece of cloth, tied around the waist of the woman, which she pulls strongly sidewards" (van Oosterhout 1993).

Taboos on activities [and sometimes food; see Chapter 3] during pregnancy have been reported from the Andaman Islands, Bangladesh, Indonesia, Irian Jaya, Malaysia and the Philippines (Biersteker 1962 and Pospisil 1956 in Voorhoeve

* Only after the first three months of pregnancy will the unborn child be thought of as a person which is in accordance with the Islam, the state religion of West Sumatra (van Oosterhout 1993).

1965; Blanchet 1984; Kuntner 1988; Lam 1991; Mangay-Angara 1981; Niehof 1988; Nillissen 1983; van Oosterhout 1993; Poerwodihardjo 1974; Priya 1992; Schiefenhövel 1982; Voorhoeve 1965). TBAs *promote adherence to* these *taboos*. Priya (1992) reports that in Thailand it is believed that "every sight, sound, touch, taste or smell, every thought and action of the mother has some reaction on the child. She therefore takes every opportunity to associate herself with objects and people which have a positive effect upon the child and with words and actions which imply success giving birth." (see also 2.2.1.1). Niehof (1988) has indicated that many of the behavioral rules for the expectant mother (and father) in Madura in Indonesia are aimed at the prevention of either a difficult labour or a retained placenta. Some of the taboos in Indonesia (in West Sumatra) [Minangkabau people] are summarized in Table 2.3.1.1a.

Table 2.3.1.1a Taboos on activities during pregnancies in Indonesia (in West Sumatra)

Taboos on activities	Argument
Bathing in a river or well, late in the morning or afternoon	may cause a spirit attack
Walking outside after sunset	"
Eating a lot	may cause a big child
Eating straight from the pan	may cause a child with a black skin
Returning before a goal is reached	may cause a difficult labour
Sitting in the doorway	"
Sitting on a stone	may cause a tough membrane
Opening a coconut on its bottom	may cause a breech delivery
Wearing the selendang* crossed, or over the back	may cause the umbilical cord to strangle the child
Rolling something on your legs	"
Being lazy	may cause a long delivery

* selendang = a batik cloth – wrapped around the body – in which babies are carried
Source: van Oosterhout 1993

In addition it has been stated that working too hard during pregnancy may cause a breech or transverse presentation (van Oosterhout 1993); Lam (1991) has reported also from West Sumatra in Indonesia [Minangkabau people] that TBAs may advise pregnant women to do a lot of physical work, but not to do much heavy work (and not to jump, not to sleep a lot and not to look at sick people). In the Andaman Islands (Kuntner 1988), Irian Jaya (Biersteker 1962 in Voorhoeve 1965; Schiefenhövel 1982), Papua New Guinea [Iatmul people] (Weiss 1990 in Kroeber 1990) and Thailand (Priya 1992) pregnant women appear to be almost as active as non-pregnant women. Women in Thailand believe that "hard work

keeps the womb loose and thus prevents the child from becoming too big and fat and causing a difficult delivery" (Priya 1992). Women in Irian Jaya believe that hard work will produce a hard working offspring (Biersteker 1962) (see also 2.4.1.1). In the area of the former 'Wisselmeren' in Irian Jaya, however, pregnant women are warned *not* to do hard work (Pospisil 1956 in Voorhoeve 1965).
Some of the taboos in Bangladesh [Bengali people] are summarized in Table 2.3.1.1b. In only a few occasions an argument is given for the taboo.

Table 2.3.1.1b Taboos on activities during pregnancy in Bangladesh

Taboos on activities	Argument
Sitting in the doorway	may cause obstructed labour
Sleeping with the head towards the door	unknown
Feeding the fakir [= Muslim Holy Man]	unknown
Standing under certain types of trees	"
Looking at a lunar or solar eclipse	"
Lying down during the time of a lunar or solar eclipse	"
Eating, cooking, cutting, tying or twisting anything as long as there is a lunar or solar eclipse	may cause the birth of a child with a shortened, tied up or twisted limb or body
Standing at ghat [= landing-stage or stairs leading to a river or a pond] or crossroads	unknown

Source: Blanchet 1984

Avoidance of these activities, together with the avoidance of '*bhut*' [= low spirit], is the most important ante-natal care in Bangladesh. "Menstruating, pregnant and parturient women are believed to be especially vulnerable to the mischievous action of 'bhut'. These ghost-like spirits play a conspicuous role in the life of rural women, far more than in that of men. ... Pregnant women fear 'bhut' very much as it is believed that spontaneous abortions and stillborn children are caused by the action of 'bhut'. .... [She] should avoid going out at inauspicious times or to places where 'bhut'are most active. A pregnant woman is not in a state of pollution, so theoretically she does not attract those 'bhut'who delight in pollution. But the villagers are not very specific in distinguishing types of 'bhut'. The word 'bhut' is most often used as a collective name in comments like: 'Bhut' like to eat women's eggs, they find the child in the womb very tasty."(Blanchet 1984)

TBAs in Indonesia are "the central figures in *preparing the offerings* for the several ceremonies or rituals during the course of the pregnancy" (Poerwodihardjo 1974). Priya (1992) emphasizes in her report from Indonesia that because seven is a number with magical and spiritual significance usually the seventh month of

pregnancy is considered to be the right time for a special ceremony. Often this is carried out during the first pregnancy only: the couple (and the unborn child) will be protected, prepared for the birth and established socially as family. Niehof (1988) has given a description of a ritual held in the seventh month of pregnancy in Madura in Indonesia. The ritual is referred to as 'rasol pellet kandong' meaning 'ritual for the massage of the belly'. "In conjunction with the actual massage treatment by the 'dukon rèmbi' [TBA] several activities are staged. The ritual should take place in the house of the expectant mother. .... The family of the expectant father has to be invited formally; both families contribute food [for the meal to be offered to the guests at the end], money, and other attributes necessary for the ceremony. .... The expectant mother is massaged, and showered with water containing flower petals. The main attributes and acts in the ceremony point to the concern with the coming end of the gestation process. Symbolically, a smooth delivery is anticipated. The TBA leads the ceremony. At the end she is rewarded for her services with food, money, and the piece of white cloth which was used in bathing the expectant mother. She has now committed herself formally to assist at the delivery."

TBAs in Indonesia (in West Sumatra) [Minangkabau people] may be capable of *determining the sex* of the unborn baby (Lam 1991; van Oosterhout 1993). From a sample study of 23 TBAs 8 claimed that they were able to do this and that they were never wrong. They examined the shape of the belly of the pregnant woman: when the fetus turned out to be on the right side, a male child was expected and when it was on the left side, they predicted the birth of a female child (Lam 1991). In Eastern Sumba a TBA is also believed to be able to predict the sex of the foetus: she derives this knowledge from the position of the baby (left or right) or from dreams (Onvlee 1973 in Niehof 1992).

2.3.2 The antenatal period *(pathological)*

2.3.2.1 BLEEDING DURING PREGNANCY
– no information could be traced –

2.3.2.2 BREECH PRESENTATION
Kuntner (1988) has noted that many TBAs in India perform *external version* in cases of breech presentation; TBAs in Malaysia and Indonesia apply *massage of the abdomen* towards the end of the pregnancy in order to get the foetus into the right position (Laderman 1982; Lam 1991; van Oosterhout 1993; Priya 1992).

2.3.2.3 TRANSVERSE PRESENTATION
TBAs in Indonesia (in West Sumatra) [Minangkabau people] may apply *massage* in cases of transverse presentation in order to get the fetus into the right position (Lam 1991; van Oosterhout 1993).

2.3.2.4 INTRAUTERINE DEATH
In cases of intrauterine death TBAs in Indonesia (in West Sumatra) [Minangkabau people] may "have the woman *drink cold water* (treated with mantras and incense)

in combination with a massage. Some TBAs also apply indigenous medicines ('obat kampungan') to clean the womb. To make the medicines work they use mantras derived from the Koran. According to the TBAs any person that wants to cure somebody, needs the permission or power of Allah. In the end it is Allah who decides whether a person will be cured or not." (Lam 1991)

2.3.3 The intrapartum period *(physiological)*

2.3.3.1 FIRST STAGE

2.3.3.1a *Immediate preparation*

In Bangladesh most pregnant women *do not prepare themselves* for the birth of the baby, because it is claimed to be too embarrassing. "Besides, it may be a bad omen; it may attract the attention of the 'bhut'*. Rather preparations will be carried out, by the prospective grandmothers but there is *never anything very much.*" (Blanchet 1984)

In Indonesia (in West Sumatra) [Minangkabau people] Lam (1991) observed a TBA washing her hands with cold water and soap. After this she boiled water for tea and for one glass of hot water into which she threw a new razor blade. A few hours of waiting followed. From the same area in Indonesia it has been reported that a TBA "brings her utensils with her: a cutting knife for the umbilical cord, coconut oil, sirih leaves, and in some cases a midwifery kit". In addition the TBA "prepares herself by washing her hands and washing the knife. The knife is not sterilised." To *protect the mother from evil spirits* the TBA may give an amulet** to her or may apply an oily substance [made from young coconut sprouts, herbs, and eal-heads] on her forehead, wrists, fingertips, and lower back. "These are vulnerable places, for spirits may enter here." A sirih-fruit may be opened and cooked in order to spread the essence around the mother. Islamic prayers may be used as well (van Oosterhout 1993). A TBA in Malaysia may insure the safety of a woman in labour by seeing that a spiny pineapple or screwpine is placed underneath the house of the woman. In addition the TBA throws a mixture of rice, salt, turmeric, tamarind, and sometimes soot, around the house which is meant as another deterrent to evil spirits (Laderman 1982).

2.3.3.1b *Physical examination*

Vaginal examinations have been reported from Indonesia, India and Malaysia (Laderman 1982; Lartson et al. 1987; van Oosterhout 1993). Laderman (1982) observed a *vaginal examination* performed by a TBA in Malaysia; the TBA washed her hands before and after she inserted her finger into the woman's vagina. A TBA in Indonesia (in West Sumatra) [Minangkabau people] "washes the vagina of the woman, puts oil on the fingers of her right hand (the left one is considered dirty), and examines the woman internally to check the birth canal and the position of the baby" (van Oosterhout 1993). In south India TBAs may perform a vaginal examination to assess progress of labour (Lartson et al. 1987).

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* 'Bhut' = low spirit; see also 2.3.1.1

** An amulet = an object worn in order to protect the wearer against evil.

In Irian Jaya [Eipo people] and in Indonesia (in Madura) *no internal manipulation* is carried out (Niehof 1988; Schiefenhövel 1982).

2.3.3.1c *Coaching of the woman in labour*

In Irian Jaya [Kiwai people] *herbal medicines* are given to the woman in labour at the time of the delivery in order to stimulate the birth process (Kuntner 1988).

Schiefenhövel (1982) has observed in Irian Jaya [Eipo people] "a TBA – the respective mother, the mother in law or other female relatives or friends who themselves have experience in childbirth – sit right beside the parturient woman holding her, stroking her, talking to her, fetching new fern-leaves as an absorbent for vaginal discharge, in short giving her all possible comfort in this materially very primitive culture. The labouring woman, *especially primiparae, are given advice* on how to squat, sit and press, not to touch their genital area etc., but rarely is this advice given in an urging, pressuring tone." In addition the author remarks: "Another element of Eipo obstetrics is to treat the pain which occurs during the dilation and bearing down periods with the oldest known treatment: *body contact, massaging and stroking,* i.e. making use of cuto-visceral reflexes, Head-zones, etc. and letting the labouring woman feel 'you are not alone'. The 'magic' elements of such straightforward practices call for the souls of the ancestors to come to assistance. These prayers add to the comforting care."

In Papua New Guinea [Iatmul people] Weiss (1990) observed female relatives also massaging the abdomen of the labouring woman between the dilation and bearing down periods. Laderman (1982) observed in Malaysia a TBA massaging the woman's abdomen gently with coconut oil. Priya (1992) has reported from south East Asia that TBAs seldom mentioned that they did anything to relieve pain. "They thought pain was a natural part of childbirth and they would only do anything about it if it would go on for a long time or if the woman would find it absolutely unbearable. .... Reassurance, massage and emotional support are the methods which TBAs use to relieve pain. [Only] when this was insufficient during a long and difficult labour a local narcotic such as betel leaf was given in conjunction with other things like prayers and massage, but only in extreme cases."

Indeed, massaging the back and belly of a woman in labour who is in a lot of pain has been observed in Indonesia (in West Sumatra) [Minangkabau people]. Now and then the TBA advised the woman "to get up and *walk up and down* because this would make her feel better and speed up the process". After a while the TBA advised her to go to the toilet. The TBA was complaining that it was taking a long time. She started to massage the woman's belly in which she pushed down from the woman's stomach with her fingers spread downwards following the outline of the baby without touching the top of the abdomen. This was done frequently till the labour pains were spaced about 4 minutes apart." (Lam 1991)

2.3.3.2 SECOND STAGE

2.3.3.2a *Position of the mother*

Women deliver in an *upright position* either kneeling, squatting, standing or sitting in Bangladesh, Indonesia, Irian Jaya [Eipo; Bime people], Thailand [Karen; Yeo people] and Papua New Guinea [Iatmul people] (Blanchet 1984; Forth 1981 in Niehof 1992; Konrad 1983; van Oosterhout 1993; Priya 1992; Schiefenhövel

1982; Voorhoeve 1965; Weiss 1990 in Kroeber 1990). In Thailand [Karen people] women may hang onto a rope or they [Yeo people] may "have a rope put under their armpits and fixed to the ceiling to support them" (Priya 1992). In Indonesia (in Madura) women may deliver in a semi-upright position, head and shoulders leaning against a wall (Niehof 1988).
Schiefenhövel(1982) states that the labouring Eipo woman in Irian Jaya is rather free to choose her body postures either out of one of these four basic possibilities: standing, sitting, kneeling or squatting (see 2.2.3.2a)(or a combination of these postures). In addition it has been noted that during the stage in which the women feel the urge to press hard they also "are in a vertical body posture, never spending more than seconds in dorso-supine position. In 6 of the 7 cases we witnessed the baby was born while the mother was in a sitting position, which was often asymmetrical in the sense that one leg was stretched out while the other leg formed an arch, the foot placed firmly on the ground. In one case the baby was born while the mother was in a symmetrical squatting posture."
Laderman (1982) has reported from Malaysia [Malay people] a *directional system* in relation to the labouring woman's position for aiding childbirth*. The position has to be arranged according to the day and hour. The author observed "about half an hour before the baby was born the TBA advised the mother to move slightly to the left. After the event [...] I asked the TBA why she had wanted the mother to change position. She told that she wanted it because the modified position was on Monday the best position for giving birth quickly and easily. After further discussion with her and other TBAs, I was able to chart a directional system for aiding childbirth. The days follow each other in counterclockwise sequence, and slight adjustments are advised for different times of the day. The days are matched humorally with the prevailing winds for each day. Just as certain foods are classified 'hot' and others as 'cold' in a humoral system without regard to their temperature [...], so too each day and each direction has its intrinsic measure of heat which does not correspond to actual thermal conditions." In addition, it has been indicated that "the possible birth positions cluster around south and west; easterly and northerly directions are avoided." (North is associated with death; east is the opposite of west, the holy direction facing toward Mecca.)

2.3.3.2b *Preparation of the birth canal/ Support of the perineum*
In Indonesia (in West Sumatra) [Minangkabau people] TBAs may examine the vagina using the right index finger when the labour pains are spaced about 4 minutes apart, and when the baby is almost through they put in the same finger again *making a circular movement around the baby's head* (Lam 1991). Laderman (1982) observed a TBA in Malaysia *dripping oil into the vaginal opening* to make the passage slippery; when the TBA took the baby's head out, she *protected the perineum against tearing by pressing a clean cloth against it.*

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* The Malays are Muslim. Islam is the state religion of peninsular Malaysia. Although other religions are tolerated the Malays are Muslim by definition (Laderman 1982).

In Irian Jaya [Eipo people] "*no maneuvres* are made to protect the perineum, yet we did not see severe ruptures, nor did the approximately 140 women with whom we were in close village contact for almost two years show signs of such previous ruptures" (Schiefenhövel 1982).

2.3.3.3 THIRD STAGE

2.3.3.3a *Birth of the placenta*

Massage of the woman's abdomen in order to stimulate the birth of the placenta has been reported from Irian Jaya by Schiefenhövel (1982). However the massage is carried out by the labouring woman herself and not by a TBA. Weiss (1990) reports from Papua New Guinea also massage of the woman's abdomen in order to stimulate the birth of the placenta.

TBAs in Bangladesh use several methods to induce the timely discharge of the placenta: *manual removal* ("pulling the placenta by putting a hand inside the mother's womb"); putting *hair or garlic in the mother's mouth;* inducing the mother to *vomit*; applying *mustard-oil on the navel; shaking or binding the waist* of the mother; and *feeding the mother with salted hot water or hot milk* (Amin/Khan 1989).

Laderman (1982) observed a TBA in Malaysia *gently pulling on the cord,* wrapping it around her hand whereupon the placenta was delivered.

2.3.4 The intrapartum period *(pathological)*

2.3.4.1 FIRST STAGE

2.3.4.1a *Prolonged labour*

TBAs in Malaysia may *rub lime* on the woman's abdomen,* as it is believed that "heat" will expel the baby. "Instead of, or in addition to the "heat" treatment, TBAs may administer a 'selusoh': *coconut oil* – which has been previously prepared by the recitation of charms – may be shaken *into a glass of water to be consumed* by the woman in labour, *or the oil may be used to massage her abdomen or vulva.*" In addition a husband may be "instructed to step over his wife's supine body in a gesture which puts to rights any attempt she might have made during her pregnancy to dominate or offend him. .... If she is *suspected of having been unfaithful to her husband,* even in thought, she may be asked to drink water in which he has dipped his penis. .... Drinking the treated water asserts the husband's dominance over his wife, and her submission to her wifely duties should facilitate her labour by placing her in a proper position as woman and wife." TBAs may request *all doors and windows to be opened* as it is hoped and believed that "the portals of the womb will [also] open to release the child" (Laderman 1982). TBAs in Indonesia (in West Sumatra) [Minangkabau people] may also ask to open doors, drawers and locks, or loosen hair-ribbons as it is believed that the quality of "opening and

* Lime = white substance (calcium oxide) obtained by heating limestone. Laderman (1982) has described lime as 'an extremely "hot" material' referring to the fact that materials [and foods] are classified 'hot' and 'cold' without regard to their temperature.

loosing" should be transformed to the mothers' body. In addition TBAs may dip a key [having an opening quality] into a bowl of tears of the mother and request her to drink it. TBAs believe that a prolonged delivery is dangerous "since a spirit or a witch can be the cause, and thus the baby will not be healthy, and perhaps die." There are other practices to speed up the delivery. The TBAs may apply coconut oil on the abdomen, or salt on the vagina. They may give something to eat: 3 bananas, an extract of young banana leaves or a mixture of 3 bananas, an egg and coconut oil. In addition they may request the mother to drink water from a river mixed with papaya and sugar, or water in which they have soaked a written prayer. All these practices are combined with prayers (van Oosterhout 1993). In several places of south East Asia supernatural help will be invoked by *drinking various sorts of exorcising water*. In Thailand, for instance, this can be made by "soaking a charmed amulet in water, pouring water over the big toe of the husband, or throwing it up on the roof and catching it. Sometimes the water will be enchanted with a spell that is humorous and obscene which must be pronounced very loudly so that the woman in labour hears it. This may help the mother to relax so that her body can give birth easily." A TBA in Malaysia was observed "praying over a glass of coconut water so that her guiding spirit was infused into it. When the labouring woman drank this the spirit was taken into her body and helped her baby to be born." (Priya 1992)
From the area of the Central Mountains in Irian Jaya it has been reported that in cases of prolonged labour a native healer is called for *magic and ritual treatment* in order to accelerate the delivery (Schiefenhövel 1978 in Kuntner 1988).

2.3.4.2 SECOND STAGE
2.3.4.2a *Management breech presentation*
– no information could be traced –

2.3.4.3 THIRD STAGE
2.3.4.3a *Retained placenta*
In Indonesia (in West Sumatra) [Minangkabau people] several methods are used by TBAs to help the placenta ['Kakak anak' = older brother or sister] out. *Strong massage, pulling the umbilical cord and/or 'local medicines'* (Lam 1991; van Oosterhout 1993). These medicines may be river-water which has been given special powers with mantras and incense ['obat kampungan'], or salted water with leaves from the papaya tree (Lam 1991). The mother may also be given water in which black rice has been soaked. In addition a heated mixture of papaya leaves with oil may be applied on the abdomen, or a *vomiting method* may be used by "placing the cord into the mouth of the mother" (Van Oosterhout 1993). Priya (1992) has reported that in general in south East Asia active measures are taken when the placenta is not delivered within two hours of the baby's arrival. In Malaysia, for instance, TBAs may also use a vomiting method by "stuffing the mother's hair in her mouth"(see also 2.2.4.3a/2.4.4.3a). TBAs in Malaysia may massage the fundus of the uterus while exerting some pressure. Or they may try to *lift the abdomen* in order to get the placenta out. In addition it is believed "that after the baby is born the stomach can descend and trap the placenta". The TBAs appear to know the signs of placental separation and will "not tug on the umbilical cord until they

note its elongation; then they will *slowly and carefully pull the cord out* to assist in the delivery of the placenta" (Laderman 1982). TBAs in India have been reported to pull out the placenta (Mukhopadhyay in Morley 1983).
In Papua New Guinea *manual removal* of a retained placenta is tried (Smit/Voorhoeve 1990).

2.3.4.3b *Postpartum haemorrhage*
TBAs in south India and Indonesia believe that postpartum haemorrhage is normal and some of them *encourage flow of 'bad' blood* (Lartson et al. 1987; van Oosterhout 1993; Priya 1992) (see also 2.2.4.3b).
TBAs in West Melanesia try to stop the postpartum haemorrhage by using a *hot compress* in the form of a heated piece of wood that is put against the vulva and the lower part of the abdomen (Kuntner 1988).
TBAs in Indonesia (in West Sumatra) [Minangkabau people] may use different methods in cases of strong bleeding: they may either give *hot water with leaves of the coffee plant, salted water,* or young *coconut milk with leaves of the hibiscus* to drink, or they may give *lime and betel leaves* to chew or put *ice between the legs* of the parturient woman (Lam 1991). TBAs from the same area may also treat postpartum haemorrhage with *sirih-leaves which are applied to the vagina* (van Oosterhout 1993).
Priya (1992) has reported from south East Asia that TBAs may use *massage* in conjunction with various *herbs.* A TBA in Thailand, for instance, told the author that she used "a special root which she dried and made into a tea which the woman had to take for a few days. At the same time she needed to make sure that she sat *near the fire* and rested and that if she did this the bleeding would almost certainly stop. If it did not, the spirits would be asked to help, these being bribed with the sacrifice of a pig if the bleeding stopped in a short time but only a chicken if it continued for two days or more."

2.3.5 The postnatal period *(physiological)*

2.3.5.1 CUTTING OF THE UMBILICAL CORD
Here we describe successively: *how, at what distance from the umbilicus* and *when* TBAs cut the umbilical cord.

2.3.5.1a *How do TBAs cut the umbilical cord?*
TBAs cut the umbilical cord with different kinds of *sharp tools* like a razor blade, a bamboo sliver, a knife, a pair of scissors etc.: all these instruments are summarized in Table 2.3.5.1a Usually the instruments are not sterilized or only washed in hot water as has been reported from Bangladesh, India, Indonesia (West Sumatra) and Irian Jaya (Amin/Khan 1989; Karan et al. 1983; Lam 1991; Mukhopadhyay 1983; van Oosterhout 1993; Voorhoeve 1965). In Java (Indonesia), however, TBAs use a sterile blade (Nillissen 1983). TBAs in Bangladesh cut the u.c. sometimes with their teeth using a cloth to avoid direct contact. This occurs when a woman has lost several small children through the action of 'bhut' (see 2.3.1.1/2.3.3.1a). Such a practice should prevent the 'bhut' from possessing the child (Blanchet 1984).

Table 2.3.5.1a Instruments to cut the umbilical cord used by TBAs in Asia

Country	Instrument
Bangladesh Indonesia Pakistan	razor blade
Bangladesh Indonesia Irian Jaya Malaysia Thailand	bamboo sliver/knife
Bangladesh	teeth in some occasion
India Indonesia Pakistan	knife
India India Irian Jaya	piece of glass sharp stone sliver
India	sickle
Indonesia Pakistan	scissors
Irian Jaya	shell
Pakistan	plant leaf or bark

Sources: Amin/Khan 1989; Blanchet 1984; ICCO 1989; Karan et al. 1983; Laderman 1982; Lam 1991; Mukhopadhyay 1983; Niehof 1988; Nillissen 1983; van Oosterhout 1993; Poerwodihardjo 1974; Rahman 1982; Schiefenhövel 1982; Traverso et al. 1989; Voorhoeve 1965

2.3.5.1b *At what distance from the umbilicus do TBAs cut the cord?*

The umbilical cord is *left long* in Bangladesh, Indonesia, Irian Jaya and Pakistan (Amin/Khan 1989; Blanchet 1984; Lam 1991; van Oosterhout 1993; Traverso et al. 1989; Voorhoeve 1965). The following authors have indicated the place where the cord is cut:

- Blanchet (1984) states that the cord is cut seven fingers from the umbilicus; Amin and Khan indicate that a significant proportion of 242 interviewed TBAs mentioned a distance of approximately 4 cm (39.3%) and 50.8% recalled a distance of 6 or 7+ cm.
- Lam (1991) observed a cord length between 10 and 15 cm.
- van Oosterhout (1993): "two places are preferred to cut, that is, either at the lenght of a finger, or at the lenght of where the cord reaches the knees or head of the child. Crossing the heart or the genitals should be avoided then, to prevent the child falling ill or becoming infertile." (see also 2.2.5.1b)

- Voorhoeve (1965) indicated that the cord is stretched along the leg of the child and then cut between the knee and foot.
- Traverso et al. (1989) reported an average cord lenght of 3.7 fingers.

In Java (in Indonesia) and in Papua New Guinea the u.c. is left *short:* 2 à 3 cm from the umbilicus (Nillissen 1983; Weiss 1990).

2.3.5.1c *When do TBAs cut the umbilical cord?*
In Indonesia (in Madura and West Sumatra), Irian Jaya, Malaysia and Papua New Guinea the umbilical cord is cut *after the birth of the placenta* (Laderman 1982; Lam 1991; Niehof 1988; van Oosterhout 1993; Schiefenhövel 1982; Voorhoeve 1965; Weiss 1990). Interviewed TBAs (n=23) stated that it is very dangerous to cut the cord before the placenta ['Kakak anak'] has been delivered as the placenta might withdraw inside the womb eventually causing the mother to die. However during training TBAs were taught to cut the umbilical cord *before* the birth of the placenta: the author observed a TBA cutting the cord before the birth of the placenta. Before cutting, the TBA first pushed the blood from the cord to the baby and the other side to the mother and then she tied it off tightly with new thick string, which had been desinfected with alcohol (Lam 1991) (see also 2.2.5.1).
On the Trobriand Islands the cord is severed *3 days after birth* (Linderkamp 1982 in Oudesluys-Murphy 1990).

2.3.5.2 DRESSING OF THE UMBILICAL CORD
TBAs may dress the umbilical cord with any of the following: *dung, ashes, ointment etc.* The dressings used by TBAs are summarized in Table 2.3.5.2.

Nillissen (1983) reports from Java (Indonesia) that the umbilical cord is dressed with a special ointment received from the health centre (while in former times 'sirih'-leaves, salt and 'kunir' ['putukan'] were used). Lam (1991) reports from West Sumatra (Indonesia) that 15 out of 23 TBAs use an antiseptic (alcohol, iodine or a mixture of both) to put on the wound. Some TBAs may use a traditional method: 'daun sicerek' [leaves of the Clausena excavata] or a heated mixture of 'sirih'-leaves and oil around the wound on the belly (umbilical base) and cigarette ashes on the stump. Niehof (1992) reports from Indonesia that "substances placed on the stump must have a 'cooling' effect, and should dry and close the wound quickly, and in addition must have symbolical meaning, for instance kitchen ashes." In Pakistan the umbilical cord is often dressed with 'ghee'. This happens immediately after the cord has been cut ("initial applications"), and frequently thereafter ("subsequent applications")*. Other dressings may be: oil, powder or antibiotics (Traverso et al. 1989).

* Traverso et al. (1989) report that these subsequent exposures to ghee may be important in the development of neonatal tetanus. The initial applications of ghee to the u.c. wound seem to

Table 2.3.5.2 Dressings of the umbilical cord used by TBAs in Asia

Country	Dressing
Bangladesh	gutted soil from oven; antiseptic dettol; mustard oil; sulfur dioxide; ashes of burned clothes; red soil; dried cow dung; saliva; smashed betel nuts
India	oil; mixture of oil and turmeric*; talcum powder; herbs; hot ashes; dyes; mercurochrome; nothing at all
Indonesia Irian Jaya	ashes
Indonesia	ground coffee
Indonesia (Java)	'ointment' [received from the health centre]
Indonesia (Madura)	mixture of turmeric* root and mashed leaves; ground coffee beans, heated water or pulverized earthen nests made by a specific sort of wasp while usually kitchen soot added; the wound is finally dressed with a sirih leaf (Piper betle)
Indonesia (West Sumatra)	daun sicerek (leaves of the Clausena excavata); mixture of sirih-leaves, oil and ashes; yellow root (kunjit)
Malaysia	ashes and turmeric; habitane-in-spirit
Pakistan	ghee**; powder derived from turmeric* plant (*ghurkanan*); cosmetic powder (*surma*)
Papua New Guinea	powder derived from pottery

* *turmeric:* Indian plant of the ginger family; its root, powdered and used to colour and flavour food
** *ghee:* purified semi-liquid butter
Sources: Amin/Khan 1989; ICCO 1989; Karan et al. 1983; Laderman 1982; Lartson et al. 1987; Niehof 1988/1992; Nillissen 1983; van Oosterhout 1993; Oudesluys Murphy 1990; Poerwodihardjo 1974; Rahman 1982; Schiefenhövel 1982; Traverso et al. 1989; Voorhoeve 1965; Weiss 1990 in Kroeber 1990.

2.3.5.3 Care of the infant

TBAs in India (in Andhra Pradesh) generally rub the placenta on the skin of the infant to remove the vernix as they believe that it is "good for removing 'lanugo'". The infant is then *bathed* with warm water using either soap or a paste of flour and *wrapped in a cloth* (Karan et al. 1983). The infant of the Iatmul in Papua New Guinea is bathed in lukewarm water as has been observed by Weiss (1990). In Irian Jaya the infant is cleaned with leaves by the mother herself with the possible help of the attending TBA (Schiefenhövel 1982). In Indonesia (in

be less important. It has been suggested that the subsequent application of ghee may cause "a decrease of the oxidation-reduction potential of the umbilical tissue, which may promote the germination and outgrowth of spores". The subsequent applying of ghee is confirmed as an important risk factor associated with neonatal tetanus, while the instruments used to cut the u.c. are not.

Madura) the infant is cleansed with kitchen soot and tamarind fruit, and bathed; as soon as the u.c. is dressed (see 2.3.5.2) and the infant is given some honey (see 3.3.2.1) it is "brought to the father who has to whisper the Islamic confession of faith in the baby's ear. After that, the baby may rest. It is put to sleep on a bed between pillows, or on an upturned rice winnow. A knife with chalk-cross on it, and a native broom, made of the nerves of coconut palm leaves, are put alongside, to protect the child from evil spirits." When the infant is seven days old a hairlock is cut or burned as the hair is believed to carry the uncleanness of the mother's womb. If the child is a girl a scratch on the clitoris is given on the same day [or when the child is between 38 and 42 days old] (Niehof 1988). TBAs in other parts of Indonesia bath the infant also and dress it in (warm) clothes (Lam 1991; Nillissen 1983; van Oosterhout 1993; Poerwodihardjo 1974). Van Oosterhout (1993) has reported from Indonesia (in West Sumatra) [Minangkabau people] that "a newborn child is cleaned with a cloth and coconut oil. Water is not used, because the baby might catch a cold." Laderman (1982) observed in Malaysia a TBA *washing the infant with oil to remove the vernix caseosa**. The TBA stated that "a heavy coating of vernix caseosa is a sure sign that the couple have been having intercourse during the latter part of pregnancy (which she considered dangerous) since she takes the whiteness of the vernix caseosa for an accumulation of semen" (see also 2.2.1.1). After removing the vernix caseosa the TBA bathed the infant with soap and warm water; the head was rinsed with cold water as it is believed that "the head is naturally hotter than the body, and if it is overheated sickness or even madness may result." After bathing the infant was dressed in a shirt and diaper, and *swaddled in a cloth.* Before it was wrapped the *arms and legs were straightened.* "The clean, dressed infant was handed to his grandmother, who touched him lightly with a pair of scissors. This was done to harden his 'semangat' [= life force], which he had newly received with the cutting of the umbilical cord." Then the infant was "laid to rest on a small mattress placed upon a floor mat, covered with a pretty cloth and surrounded on either side by bolsters". Lam (1991) reports from West Sumatra in Indonesia that TBAs clean the mouth of the infant with their little finger which they have dipped in either honey, 'asem' (tamarind) or water. The TBAs use their little finger without cleaning their hands first.

The infant is then washed with warm water and soap, rubbed with ('Melaleuca') oil [vernacular name: 'minyak kayu putih'] and powdered. The infant is then swaddled tightly as it is believed that this "makes the infant feel comfortable and quiet and makes sure the infant will get nice, straight, long arms and legs". The author observed a TBA "putting the rest of the umbilical cord upwards against the infant's body and fixing it with bandages all around the body. Then the infant was weighed. After this the infant was wrapped in a brand new clean cloth in a special tight way which left only the infant's face visible. Both arms and legs could not be moved anymore and were stretched. During the wrapping she muttered magic formulas." From the same area in Indonesia van Oosterhout (1993) has reported

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* see 2.2.1.1, pg. 16.

that wrapping the child in a piece of cloth is done "as a protection against a cold, because the child is still considered to be hot, and against sudden movements that would break the cord that should dry on the body".

2.3.5.4 Care of the mother after delivery

The mother is *bathed* by TBAs on the Andaman Islands, Indonesia and Malaysia (Kuntner 1988; Laderman 1982; Niehof 1988; Nillissen 1983; Poerwodihardjo 1974). A TBA in Malaysia was observed to clean the mother's vulva with heated water after massaging the abdomen with coconut oil to expel "bad" blood. The TBA had added "hot" leaves with a pleasant or sweet smell to the water. Then the mother changed her sarong and moved to a clean mat and pillow; after this she got a hot stone wrapped in cloths which she placed on her abdomen (Laderman 1982). In Indonesia (in Madura) the mother is washed with water containing kitchen ashes, tamarind fruit, and salt. "After that, she is allowed to stand up and have an ordinary bath" (Niehof 1988). TBAs in Java (Indonesia) press down on the abdomen of the mother to remove the postpartum blood ['darah kotor' = dirty blood]. Then the mother is carefully *massaged* in order to "restore all the organs in her body" and afterwards she is bathed (Nillissen 1983). In Indonesia (in West Sumatra) [Minangkabau people] Lam (1991) observed a TBA cleaning the mother a bit with old but clean rags and afterwards putting rags between the mother's legs. The mother was given a clean old sarong and told that the TBA would come to see her the following day. From the same area in Indonesia van Oosterhout (1993) has reported that the mother is cleaned with coconut oil.

TBAs in Indonesia as well as in Polynesia [people: Pukapukans] apply a *bandage* around the abdomen (Niehof 1988; van Oosterhout 1993; Poerwodihardjo 1974). In Indonesia (in Madura) this bandage consists of a long piece of cloth ('bang-kong') which is wrapped tightly around the mother's waist and belly "so that she is hardly able to walk". The intention is to restore the body's shape (see Table 2.3.5.4). [Forty days after birth the TBA massages the mother 'to put the womb back into place'] (Niehof 1988).

The mothers are *kept indoors* in India (in Andhra Pradesh), Indonesia (in Madura and in West Sumatra), Malaysia and Papua New Guinea (see also 2.2.5.4/2.4.5.4). In Papua New Guinea [Iatmul people] for a few days; the mother is only allowed to leave the house for a very short time and this restriction has to be continued "until the cord drops". Meanwhile she can rest (Weiss 1990 in Kroeber 1990). In India the mothers are "isolated and confined to a small dark corner for three to four weeks in the majority of households and in a few up to 40 days. They are allowed to leave the delivery area for toilet requirements." (Karan et al.1983). In West Sumatra [Minangkabau people] the mother and child are confined to the house for thirty or forty days. The mother has to take a lot of rest and has to be helped. She is not allowed to cook: she would pollute the food as she is still 'unclean' for a couple of weeks (van Oosterhout,1993). Niehof (1988) reported from Madura in Indonesia a similar use: the mother "should confine herself to the house and compound, and should not come near the kitchen or participate in cooking and cleaning activities." The mother has to follow this rule because she

and the child are believed to be in a state of transition and therefore very vulnerable to supernatural evil forces. In addition they are not only contaminated, but also contaminating their environment. The mother also has to observe other behavioral rules (see Table 2.3.5.4).

In Indonesia the mother may be given indigenous *herbs* "to accelerate the exit of 'unclean blood' from the uterus and the excretion of mother's milk". In addition, "the TBA will visit the mother daily for 1 or 2 months after the birth" (Poerwodihardjo 1974). The mother in Madura in Indonesia may be given a drink of water containing ashes and kitchen soot* ('landhana batok'). The mother is expected to drink this herbal medicine ('jhamo') three times a day during a forty-day period. In addition the mother is rubbed with herbal ointments, especially 'parem baba' to expel the 'dirty blood' from the body. In summary, the purposes of treatment with medicine and ointments stimulate the nursing function, freeing the body from contamination and pollution and regaining the body's normal shape (see Table 2.3.5.4) (Niehof 1988).

Table 2.3.5.4 Care of the mother in the postnatal period in Madura in Indonesia

Treatments and rules	Intentions
Drinking herbal medicines *(landhana batok; jhamo anga)* Rubbing the body with ointment *(parem baba)* Refraining from too much resting	Expelling the 'dirty blood'
Drinking herbal medicines *(jhamo anga; jhamo ronronnan; jhamo paka)*	Stimulating the nursing function
Drinking *jhamo paka* Applying a bandage *(bangkong)*	Restoring feminine attraction and the body to its pre-pregnant shape
Cleaning the body with a mixture of ashes, kitchen soot and tamarind fruit Rubbing the body with ointment *(parem atas)*	Cleaning and purifying the body externally
Keeping at a distance from the kitchen, not sweeping the yard, etc. Keeping away from ominous places Not leaving the compound unless necessary Not going to public places	Preventing the 'unclean' woman from contaminating her environment, and protecting her from malevolent spirits

Source: Niehof 1988

* Kitchen soot or ashes appear to be important in the treatments of and ceremonies for mother and child. "These elements are not only regarded as purifying, but they also serve the purpose of linking mother and child more closely to the earth. The kitchen with the hearth symbolizes the earthly and the domestic context and this makes sense if one keeps in mind that the period of childbirth and the first forty days after it, is regarded a transitional and hazardous one." (Niehof 1988)

In Bangladesh, Malaysia and on the Trobriand Islands TBAs try to keep the mother warm by lighting a fire. On the Trobriand Islands mother and child stay in bed near the fire during the first month after birth (Blanchet 1984; Kuntner 1988). Blanchet (1984) indicates that "the mother is believed to need *warmth* after giving birth. She had the warmth of her baby before birth but afterwards she is empty and cold. Warmth will comfort her and ease her pain. It will help the uterus to retract and the mother to get back her shape. Heat dries up the womb and heals the raw flesh." The author states also that the custom of lighting a fire after birth is found all over Southeast Asia, including Burma, Cambodia, the Philippines and Thailand. In addition "apart from lighting a fire, some TBAs use the 'shek' method: when the blood loss decreases, clean rags are rolled into a ball, heated up over red ashes and placed against the vagina. This treatment is especially good for healing tears. 'Shek' can be administered in a different way: some earth may be mixed with cowdung heated up covered with a cloth and the parturient is made to sit on it." *Smoke* is believed to be beneficial: another 'shek' method "consists of roasting twelve spices ('goram mosala') in a hole in the ground. When the fumes come up, the woman is made to squat over the hole. The latter is considered to be a good treatment for a prolapse of the uterus." Priya (1992) reports that smoke is not only believed to purify but also to keep away evil spirits. In India (in Andhra Pradesh) "a slow fire of coal and cowdung is allowed to smoulder on the doorsteps for 10-21 days in the belief that this measure wards off evil spirits from coming near the mothers and infants"* (Karan et al. 1983).
In Indonesia (in Madura) only a few people nowadays maintain the custom of keeping a woodfire burning in front of or on the front porch. Visitors are then requested to hold their feet above this fire in order to prevent them from causing illness or being a bad influence to the newborn (Niehof 1988). In Malaysia the new mother is believed to enter in a 'cold' state after delivering her child and the subsequent loss of a quantity of ['hot'] blood. This 'cold' state lasts until approximately 40 days after birth. While the mother is bathed, the men of the family set up the "*roasting bed:* a simple wooden frame with boards across its width on which an old floor mat is placed". The mother then lies upon this bed. Beneath the bed, or sometimes next to it, a large pot or box containing a wood fire is placed. "The heat of the fire is thought to dry up the lochia faster...., to cause the blood to circulate faster (since the mother's 'cold' state slows down the circulation of blood), to encourage the rapid involution of the uterus, to close up the cervix, thus avoiding the possibility of pregnancy in the near future, and to aid the mother in regaining her youthful figure and tight vagina." (Laderman 1982)

2.3.5.5 Care of the placenta

The placenta is *buried* outside or inside the hut according to reports from Bangladesh, India, Indonesia, Malaysia and Papua New Guinea (Blanchet 1984; Karan et al. 1983; Laderman 1982; Lam 1991; Nillissen 1983; van Oosterhout 1993; Poerwodihardjo 1974; Weiss 1990 in Kroeber 1990). In Bangladesh (in

* In addition certain articles, generally made of iron, like the sickle or a knife are kept under the mother's pillow in order to expel evil spirits (Karan et al. 1983).

Miapur area) the placenta is buried "in a deep hole three feet deep. The great fear is that a dog, a jackal, or some other scavenging animal may dig up and eat the placenta in which case most serious consequences are expected to follow: the mother's milk will dry up, the child will become ill and probably die. In other places the placenta will be buried inside the hut, or it will be covered with a cloth as soon as it is out so that evil air does not harm it, or it will be buried in an earthenware pot." (Blanchet 1984). In India (in Andhra Pradesh) "the placenta is buried outside the house covering it with a pot or leaves so that no one could trample on it" (Karan et al. 1983). In Indonesia the placenta is buried "with a small ceremony at a place located by the TBA. It is usually put in an earthen bowl and carried by the father escorted by the TBA and the family." (Poerwodihardjo 1974). In Indonesia (in Java) the placenta ['Ari-ari'] is cleaned with water, wrapped in a banana-leaf and – together with a needle, a thread, a coin, some sugar, rice and salt – put in a coconut-shell. The father of the child digs a hole in the ground near the house in order to bury the placenta (Nillissen 1983). In Papua New Guinea [Iatmul people] the placenta is put in a coconut and buried in the forest (Weiss 1990).

Lam (1991) reports from West Sumatra (Indonesia) [Minangkabau people] that the placenta ['Kakak anak' = older brother or sister] has to be washed with water as it is believed that if this is neglected the infant will fall ill. In Malaysia the placenta is believed to be the baby's 'little brother' which develops during the second month inside the womb. As the baby grows, it grows away from its sibling and hence develops the umbilical cord. When the baby is born this little brother is buried somewhere near the house." (Priya 1992). In fact, all over Indonesia the placenta is regarded as one of the baby's siblings. It is believed "to be the material form of one of the four invisible siblings, who accompany the baby at birth, and who will reappear before their earthly companion at the end of his or her life". This belief refers to the necessity of taking good care of the placenta (Niehof 1988) (see also 2.2.5.5/2.4.5.5).

In Madura the placenta is "cleansed with the same ingredients as the baby was washed with (see 2.3.5.3). It is salted, and seasoned with all kinds of spices, both of the 'hot' and the 'cool' type.

Then it is wrapped in white cloth, and put into an earthenware jar together with some rice, maize, coins, a piece of script, and a needle or a pencil. The jar is kept in or near the house for some time, and after that it is thrown into the sea, buried, or suspended from the overhanging lower edges of the roof." During the period just after childbirth, mother, infant and placenta are "considered very close, almost as if the same blood still runs through their veins. The mother's well-being will directly affect that of the baby. Illness of the mother is thought to be caused by an inadequate treatment of the placenta. As a therapy for the mother, salt and spices will be added to the placenta." (Niehof 1988). Laderman (1982) observed in Malaysia that "the placenta was washed thoroughly in water into which lime juice was squeezed. After the placenta had been washed, it was placed inside a cloth which lined the inside of half coconut shell. Salt, tamarind, a small piece of white cloth and a bit of absorbent cotton were added. The TBA tied up the cloth, making it into a bag. Then it was ready for burial." The father of the infant buried the placenta a few hours after birth beneath a young palm tree while

prayers for the dead were said. "The salt and tamarind were added as preservatives and as a gatekeeping mechanism to keep the world of the spirits apart from that of the spirit made flesh. The bits of cloth and cotton were symbolic representations of the placenta's status as semi-human. .... The placenta appeared to be considered to be the older sibling of the infant, and as such, entitled to a decent burial". In Thailand [Karen people] the placenta (and cord) is put in a bamboo water pipe (often now a plastic bottle) and buried near a tree or tied to the branches; the Lahu people put the placenta (and cord) in a bamboo water pot and bury it under the house (Priya 1992). *Placing the placenta in water* (sea, river) has been reported from Indonesia (in West Sumatra) [Minangkabau people] and Irian Jaya (Lam 1991; van Oosterhout 1993; Pattipeme 1962 in Voorhoeve 1965). When people in the Baliem Valley (Irian Jaya) are living far from a river the placenta may be *burnt* (Pattipeme 1962 in Voorhoeve 1965). In the northern part of Irian Jaya people may *hang the placenta in a palmtree* and burn it later near the hut. In the southern part the placenta is *put on high totem poles* and left to decay (Voorhoeve 1965).

2.3.6 The postnatal period *(pathological)*

2.3.6.1 IMMEDIATE CARE OF THE ASPHYXIATED NEWBORN

Blanchet (1984) reports from Bangladesh that when the child does not breathe after birth TBAs *milk the cord* from the maternal end towards the child (see also 2.2.5.1c/2.2.6.1). Blanchet remarks that "the techniques employed to resuscitate a newborn child demonstrate clearly the belief that the placenta is the seat of some life-matter" and gives a description of milking the cord: "fingers are pressed down along the cord from the placenta as when one milks a cow, so that life re-enters the child". In addition, "if this fails, *the placenta is trampled on and sometimes heated up* or roasted so that life may run back along the cord to the child".

Milking the cord or roasting the placenta or putting it under the surface of hot water in order to revive asphyxiated infants have also been reported by Raina/ Kumar(1989) from India (Ambala district in Haryana). Waiting for cord pulsations to stop before tying and cutting appeared to be another measure. Pushing extra blood into the infant and warming up the placenta were related to the belief that the newborn's life depended on the transfer of blood from the placenta to the infant through the cord. In addition it has been remarked that "the responses of the TBAs to birth asphyxia are determined by the belief that life during the postnatal period depends on the placenta and umbilical cord but not on the establishment of breathing. Consequently, no effort is made to revive a baby if the cord is blue, cold or non-pulsatile, because it is then presumed that the heart is not functioning." Other measures used by TBAs in order to stimulate asphyxiated infants were *flicking the sole, patting the back* after keeping the newborn upside down, instilling *onion juice into the nostrils, exercising the limbs, wrapping in cotton wool, pressure on chest,* or *other* (giving drugs, drops of water, bathing, blowing into ears and nostrils, smelling brandy, breast-feeding, hot compress on fontanelle, beating on a metal plate and pricking with needles). Mouth-to-mouth resuscitation, cleaning the mouth and keeping the newborn upside down were mentioned by the TBAs as well, but these appeared to be measures learnt during TBA

training. In addition the authors (Raina/Kumar 1989) state that studies from Burma, [Ethiopia in Africa], India and the Philippines also describe practices "based on the transfer of new life and strenght to the baby through the placenta, umbilical cord and anterior fontanelle: 'milking' the cord, heating the placenta, waiting for cord pulsations to stop before tying and cutting it, and blowing air on the anterior fontanelle".
In Papua New Guinea [Iatmul people] a sneezing method is performed when the newborn does not breathe immediately after birth by putting *a blade of grass into the newborn's nose* (Weiss 1990).

The methods of immediate care of the asphyxiated newborn used by TBAs in Asia are summarized in Table 2.3.6.1.

Table 2.3.6.1 Methods of immediate care of the asphyxiated newborn used by TBAs in Asia

Country	Method
Bangladesh Burma India Philippines	Milking the cord; heating the placenta or waiting for cord pulsations to stop before cutting it
Bangladesh	Trampling on the placenta
India	Patting on sole/back; instilling onion juice into the nostrils; exercising the limbs; wrapping in cotton wool; pressure on chest; giving drugs or drops of water; bathing, blowing into ears and nostrils; smelling brandy; breast-feeding; hot compress on fontanelle; beating on a metal plate; prickling with needles
Papua New Guinea	Putting a blade of grass into the nose

Sources: Blanchet 1984; Raina/Kumar 1989; Weiss 1990

2.4 Latin America

2.4.1 The antenatal period *(physiological)*

2.4.1.1 PRENATAL CARE
An important part of prenatal care exists of *massage of the abdomen* according to reports from Guatemala, Jamaica and Mexico [Maya people] (Cosminsky 1982b; Jordan 1983; Kitzinger 1982; Naaktgeboren 1989; Nadig 1990 in Kroeber 1990). In Guatemala [people: Maya Indians; Ladinos] TBAs are usually called by the fifth month of pregnancy in order to examine the pregnant woman. In the case of a primipara TBAs are approached earlier. After the first examination (existing of looking for the signs of pregnancy, such as the color of the nipples, the size and shape of the breasts, and the swelling and height of the abdomen, and of feeling

the position of the baby) TBAs visit and examine the woman every 20 days or monthly until the last month when the woman comes weekly. During these examinations massage of the abdomen is performed: the TBA "rubs a little oil into her hands, warms them over some coals, and slowly touches each side of the woman's abdomen, feeling the position and head of the baby, gently but firmly rubbing and massaging the area, moving her hands in opposite directions across the abdomen and along the sides". It has been emphasized that this massage must be done "poco a poco"(little by little), not roughly (Cosminsky 1982b). In Mexico [Maya people] massage takes place once a month and from the ninth month while massaging the abdomen the TBA is determining the position of the child as well (Nadig 1990). How this is performed has been described by Jordan (1983): the TBA "spreads some oil or vaseline into her hands and strokes the abdomen while talking to the pregnant woman. She discusses how the woman has been feeling and talks about the expected date of birth. She probes a little deeper to determine the baby's position. .... After a few minutes of light circular movements, the TBA 'lifts up the uterus' by pushing her fingertips into the woman's side underneath the uterus and pulling it towards her. She explains that this has to be done in order to avoid that, in the end, the afterbirth will stick. The TBA then moves over to the other side of the woman and lifts the uterus from that side too. Back massage is following now. The TBA applies firm and even pressure to the back of the pregnant woman while moving the palm of her hand downward along the woman's spine. Then the woman turns over and the same is repeated for the other side of the back. At last the TBA is raising the woman's knees so that her feet are flat on the ground close to her buttocks, grasping her hands, and pulling her to a standing position. Now, after the massage, the woman is expected to rest in her hammock for a while."
Kitzinger(1982) refers to the use of castor oil or olive oil while massaging the abdomen.

Promoting adherence to taboos on activities has been reported as part of the TBA's prenatal care from Guatemala [people: Maya Indians; Ladinos] and Jamaica (Cosminsky 1982b; Kitzinger 1982). E.g. in Guatemala it is believed that "a woman who fails to clean her grinding stone or tie her loom promptly will have a lazy child who, when birth is imminent, will be too lazy to be born easily" (Priya 1992)(see also 2.3.1.1). Some of the taboos in Jamaica are summarized in Table 2.4.1.1
Kitzinger(1982) remarks that the most important taboos "involve the strict separation of the principles of life and death". In addition she states that "TBAs sometimes smile over these prohibitions and pride themselves on being up-to-date. Nevertheless, they give tacit support to the myths existing in the culture and explain that, for example, the prohibition on using a treadle sewing machine in advanced pregnancy is useful because many women sit long hours over their machines and get severe backache as a result."

Providing herbal medicines is an important part of TBAs' prenatal care in Colombia. These medicines (e.g. marjoram, platanillo, latijo, anise, canela) are prepared

Table 2.4.1.1 Taboos on activities during pregnancy in Jamaica

Taboos on activities	Argument
Looking at a dead body	may cause the death of the baby and sometimes of the mother
Holding another woman's baby under the age of three months	may cause the death of her own baby
Drinking too much water	may cause 'drowning' of the baby
Stretching the arms above the head	may cause scorching of the baby's neck
Walking over a floor which is being scrubbed with soap	may cause indigestion
Stepping over a donkey's tethering rope or a broom	may cause prolonged pregnancy
Becoming emotionally disturbed	may cause the birth of a 'marked' child*
Using a treadle sewing machine in advanced pregnancy	unknown

* People say: "If you are killing a fowl and you sorrow for that fowl your child come with some parts of the looks belonging to that fowl." For this reason a pregnant woman should never wring a chicken's neck.
Source: Kitzinger 1982

as an infusion* to be taken orally. Some TBAs give injections, other do nothing at all (Durenkamp 1970; Priester 1970, unpublished report; Smits 1992, personal communication**). Herbal teas and baths may be recommended by TBAs in Guatemala [people: Maya Indians; Ladinos]. In order to prevent miscarriage, for example, TBAs may advise to take 'Membrillo' [*Cydonia oblonga*] and shavings from kaolin tablets called 'Pan del Señor'[cut upwards in form of a cross, while saying three "Our Fathers"], to boil this together and drink the tea. TBAs may advise to bathe in avocado pit, avocado leaves and salt to soften the body before birth; or, for prenatal pains, to bathe in hot water with avocado leaves and salt (Cosminsky 1982b). TBAs in Mexico [people of Yucatan] *advise taking vitamins* when a pregnant woman complains about morning sickness (Jordan 1983).
Questioning of TBAs in Haiti (in the Artibonite Valley and in the Jacmel area) revealed that there is *no prenatal care* as there is superstition about it. "There is a taboo: the TBA must not enter the yard where the mother cooks while she is pregnant. Whatever advice a TBA might give during pregnancy this would have to be offered in a kind of "offhand" way: e.g., during an encounter at the market-place, or while washing clothes in the stream. The TBA apparently fears being

* Infusion: see footnote pg. 15.

** J. Smits worked as a nurse for 2 years (1969/1970) in the 'Departamento de Nariño' in Colombia. She visited 76 hamlets in 3 districts where she met and interviewed 58 TBAs. She investigated their practices and their ability for training.

blamed if the baby should be malformed or if the delivery should go badly; any advice she might give during the pregnancy might be looked upon by the family as the cause of the mishap." (Berggren et al. 1983)

2.4.2 The antenatal period *(pathological)*

2.4.2.1 BLEEDING DURING PREGNANCY
– no information could be traced –

2.4.2.2 BREECH PRESENTATION
TBAs in Guatemala [people: Maya Indians; Ladinos], Jamaica and Mexico [Maya people] may perform *external version* in cases of breech presentation (Cosminsky 1982b; Jordan 1983; Kitzinger 1982; Kuntner 1988). TBAs in Mexico "locate the head and the hip and by applying strong, even pressure to these parts, shift the baby's body into the more favorable head-down position. The procedure is sometimes painful but the women prefer it to a Caesarean section in the hospital." (Jordan 1983). In addition the author stated that "TBAs are experts at turning the baby even when the woman is in labour, as long as the breech is not engaged which means that it has not yet become firmly wedged in the birth canal."

2.4.2.4 TRANSVERSE PRESENTATION
In cases of transverse presentation TBAs in Guatemala [people: Maya Indians; Ladinos] and Mexico [Maya people] may perform an *external version* of the baby in utero just like they do in cases of breech presentation (see 2.4.2.2) (Cosminsky 1982b; Jordan 1983).

2.4.2.4 INTRAUTERINE DEATH
– no information could be traced –

2.4.3 The intrapartum period *(physiologlocal)*

2.4.3.1 FIRST STAGE
2.4.3.1a *Immediate preparation*
In Jamaica TBAs "light the stove, fetch water and set it to boil, make the bed up with newspaper, and tear up rags in which to wrap the baby" (Kitzinger 1982). As soon as a TBA in Mexico [Maya people] is called for a delivery "she walks to the woman's house to assess the situation. She carries a case with among other things a sheet of clear plastic to place under the expectant woman, a plastic apron, a gown, a cap, a face mask, and stainless steel bowls for washing her hands and for cleaning the scissors used to cut the umbilical cord." Other measures are taken as the woman in labour is considered to be extremely vulnerable to the influence of spirits of the bush, doors are kept shut and rags are put against all cracks in order to keep them out (Jordan 1983). In Guatemala [people: Maya Indians; Ladinos] TBAs are called when labour pains begin. Then they may check "for the intensity and frequency of contractions, the position of the baby's head, the breaking of the amniotic sac, and the sweating and heat of the woman, which are regarded as signs of the imminency of the birth". Then they may put a straw mat or a plastic sheet

and a clean cloth under the woman to receive the baby (Cosminsky 1982b). As soon as a TBA in Haiti (in the Artibonite Valley) is called for a delivery she may give advice and comfort to the family. In homes where 'Voodoun' is practiced, there is superstition about having much 'light' on the subject, and TBAs have "recounted performing the entire delivery .... underneath a sheet". TBAs in the Jacmel area in Haiti want the family to be responsible for keeping ready a pot of boiled water and bed sheets as soon as they are called for a delivery. They may themselves bring scissors, a new or old razor blade, alcohol and string with which they tie the umbilical cord (Berggren et al. 1983). TBAs in Ecuador wash their hands before birth and during the initial stages of labour (Baquero et al. 1981).

2.4.3.1b *Physical examination*
TBAs in Ecuador may perform *vaginal palpation* in order to determine the progress of the delivery. A fatty substance is also applied to the mother's abdomen (Baquero et al. 1981).
In Guatemala [people: Maya Indians; Ladinos], Haiti and Mexico [Maya people] TBAs *don't do vaginal examinations.* In Haiti (in the Artibonite Valley) TBAs believe in letting nature take its course and perform neither vaginal nor rectal examinations. TBAs in Mexico believe that the TBA's hands should stay out of the birth canal; they massage the parturient woman while feeling for the head of the fetus in order to see if it is engaged or still moving freely (Berggren et al. 1983; Cosminsky 1982b; Jordan 1983).

2.4.3.1c *Coaching the woman in labour*
TBAs in Ecuador and Jamaica encourage the woman to *walk around during early labour* (Baquero et al. 1981; Kitzinger 1982).
Massage of the woman's abdomen and back has been reported from Guatemala [people: Maya Indians; Ladinos], Jamaica and Mexico [Maya people] (Cosminsky 1982b; Jordan 1983; Kitzinger 1982; Nadig 1990 in Kroeber 1990). Kitzinger (1982) indicates that TBAs in Jamaica treat backache by massage of the back, and describes this massage: "The TBA uses a band of cotton cloth of approximately a fore-arm's width, which she extends round the mother's sacrolumbar region and, facing her patient, pulls this cloth alternately from side to side during contractions to produce strong friction." TBAs in Guatemala give massage if the woman has much pain. The massage takes the form of downward movement on dorsal and frontal sides (Cosminsky 1982b). Moreover, TBAs in Jamaica *tell women to breathe lightly* in the late first stage as it is believed that the fetus can ascend into the woman's chest and "by inhaling more the fetus may come up". The author states that "the TBAs are well aware that this cannot happen but use the myth to encourage their clients to breathe shallowly and quickly". If there is no progress of labour some TBAs "wrap the mother in hot, wet towels and when the skin is warm, remove them and massage the entire body with olive oil".(Kitzinger 1982) Jordan (1983) states that coaching the woman in labour in Mexico [Maya people] means also *explaining the progress of labour:* the TBA "will describe how contractions will come closer, how the woman has to push and how the baby will be born. Her teaching is demonstrative rather than verbal. For example, she doesn't tell, but *shows* how the woman will have to push with all her strenght." The

husband of the parturient woman and the woman's mother are attending too and give the woman the mental and physical support she needs: they encourage her and always let her know that she is not alone. Together with the TBA they rub her abdomen, her back, her legs and press down on the thighs whenever a contraction comes.

2.4.3.2 SECOND STAGE

2.4.3.2a *Position of the mother*

An *upright position* either kneeling, sitting, squatting or standing is the most common position for delivery in Colombia, Ecuador, Guatemala [people: Maya Indians; Ladinos], Haiti, Jamaica, and Nicaragua (Baquero et al. 1981; Berggren et al. 1983; Cosminsky 1982b in Naaktgeboren 1989; Kitzinger 1982; Smits 1992, personal communication; as reviewed by Statius van Eps 1954). The woman in labour in Guatemala sometimes supports herself with a rope which is attached to the roof (Naaktgeboren 1989). Cosminsky (1982b) has reported from Guatemala that the most common position is "kneeling, fully clothed, and grasping the edge of a bed or a chair to have force, with the TBA catching the baby from behind. If the husband is present, he is supposed to assist during the birth by supporting the woman, usually holding her under the arms, in order that he knows what the woman has to suffer. If he is not present, a female relative usually assists." A woman in Mexico [Maya] may deliver kneeling on a mat (Jordan 1989), but a *(semi) recumbent position* has also been observed and described: "a parturient woman is lying crosswise in a hammock, her feet propped in its folds, her legs slightly drawn up and apart. A 'head helper' (often the husband) supports her with his arms under the woman's shoulders. The woman is in this way able to pull up at the height of a contraction, raising herself almost to a sitting position. As the contraction fades away, she lets herself down to rest. When the birth is imminent, the woman may move from her hammock to sit on the legs of a wooden chair which has been put on its side. The woman's feet are put on the floor and when a contraction comes on, she can pull herself up by holding on to a rope or a 'rebozo' (= the traditional Maya shawl) which is attached to the roof. The TBA is sitting in front of her while two helpers are holding the woman's feet and knees in order to enable her to push more effectively. Sometimes a woman is sitting on her husband's lap while delivering." (Jordan 1983)

In rural Haiti women may also deliver in a semi-seated position often being supported by the husband or a close relative (Berggren et al. 1983).

2.4.3.2b *Preparation of the birth canal/ Support of the perineum*

TBAs in Jamaica may *massage the perineum with olive oil,* castor oil or the oil from 'toona' leaves. *Hot compresses* are also used (Kitzinger 1982).

TBAs in Mexico [Maya people] never rupture the membranes. They frequently observe the membranes appearing externally as a bubble: "this bubble with the size of a tennis ball fills up at the height of a contraction and recedes as the contraction subsides, thereby cushioning the baby's head and allowing a gradual stretching of the perineal area" (Jordan 1983).

2.4.3.3 THIRD STAGE

2.4.3.3a *Birth of the placenta*

Massage of the woman's abdomen with 'Belladonna' ointment in order to stimulate the birth of the placenta has been reported from Colombia. TBAs may also *hit the woman's back with a pillow* or ask the woman to *blow into a bottle* (Smits 1992/ personal communication).

2.4.4 The intrapartum period *(pathological)*

2.4.4.1 FIRST STAGE

2.4.4.1a *Prolonged labour*

Herbal teas may be given in cases of prolonged labour as has been reported from Guatemala [people: Maya Indians; Ladinos], Haiti and Jamaica; in Guatemala* teas are usually made of 'hot' herbs and sometimes mixed with liquor, while in Jamaica especially thyme and spice teas are given. These teas may relieve the pain of a difficult or delayed delivery (Berggren et al. 1983; Cosminsky 1982b; Kitzinger 1982; Naaktgeboren 1989). TBAs in Guatemala may also *apply a heated plaster* with salt: such a plaster may be made of egg white, mashed rue leaves ('pimiento de chapa') and rum in a cloth, which is then put on the front and back of the woman's abdomen; a plaster may also be made of coconut milk mixed with egg white (Cosminsky 1982b). A woman in labour in Jamaica may also be urged to take *deep breaths of a sweat-soaked shirt* of the baby's father in order to accelerate labour (Kitzinger 1982). TBAs in Mexico [Maya] may give the woman in labour *a raw egg to swallow.* "The woman swallows it with a shudder of revulsion. She immediately throws it up again and this usually results in powerful contractions. If this fails, an injection with vitamin B complex might be given." (Jordan 1983)

In Colombia (in Nariño) two methods of treating a prolonged labour are administered by TBAs: 1) the woman in labour may be put on a blanket. Four people will each hold a corner of the blanket and then *toss the woman in the blanket,* 2) the woman may *be 'hung' from the ceiling* supported by a rope under her armpits (Durenkamp 1970).

In the Maya society in Guatemala prolonged (obstructed) labour may be attributed to misbehavior of the woman in labour. The woman is requested *to confess her guilt:* with a burning candle she has to ask God for forgiveness. The TBA guides the ceremony. When there is no result from the confession the TBA will ask the

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* The herbal 'teas' in Guatemala given either for pain or prolonged labour, may be:
- tea of root of 'acuzena' *(Lilium longiflorum).*
- decoction of 'kispar' *(Petiveria allionacea).*
- boiled 'pimpinela' *(Poterium sanguisorba)* and rum ('aguardiente').
- tea of clove, cinnamon, 'pimpinela' *(Poterium sanguisorba),* oregano, 9 leaves of 'Flor de Pascuas' (pointsettia) and 20 drops of 'esencia maravaillosa' (this remedy will either stop pains or make them become stronger, and will give the woman strenght) (Cosminsky 1982b).

husband to hit his wife with his sandal three times upon her back while saying that whatever she has done she is forgiven now. This forgiveness must finally result in a proceeding labour (Cosminsky 1982b as reviewed by Naaktgeboren 1989).

2.4.4.2 SECOND STAGE

2.4.4.2a *Management breech presentation*

In cases of breech presentation TBAs in Jamaica "allow the baby's body to hang by its own weight, and finally *raise the legs up* over the mother's pubis to deliver the aftercoming head" (Kitzinger 1982). TBAs in Mexico [Maya people] watch carefully that *the arms* come down alongside: if it doesn't happen they will *pull them down* (Jordan 1983).

2.4.4.3 THIRD STAGE

2.4.4.3a *Retained placenta*

In cases of a retained placenta TBAs use a *vomiting method* by either inserting a feather, braids, (two) fingers or a long onion (a kind of leek) in the mother's throat, or giving the mother a raw egg to swallow or (almond) oil to drink as has been reported from Colombia (in Nariño), Ecuador and Guatemala [people: Maya Indians; Ladinos] (Baquero et al. 1981; Cosminsky 1982b in Naaktgeboren 1989; Durenkamp 1970; Smits 1992, personal communication)(see also 2.2.4.3a/ 2.3.4.3a). TBAs in Colombia may also request the mother to *blow strongly into an empty bottle* (see 2.2.4.3a) or they may *hit the woman's back with a pillow* (Durenkamp 1970). *Massage of the abdomen* with 'Belladonna' ointment may also be performed in Colombia (in Nariño) (Priester 1970). In Haiti a *broom method* is administered by TBAs by "sweeping" over the abdomen with a broom* (see also 2.2.4.3a). Other methods used in Haiti may be *blowing on the severed end of the umbilical cord, or calling a dog to sit outside the door* (Berggren et al.,1983). TBAs in Ecuador may place *a receptacle with heated brandy close to the vagina* to help loosen the placenta (Baquero et al. 1981).

TBAs in Guatemala believe that a retained placenta might rise up in the body of the mother and cause her to choke: they cut the cord and tie it to the mother's leg while she is taken *to a doctor* (Cosminsky 1982 in Oudesluys-Murphy 1990). TBAs in Mexico [Maya people] would send for a doctor to remove a retained placenta manually (Jordan 1983).

2.4.4.3b *Postpartum haemorrhage*

If there is bleeding in the third stage the TBA in Jamaica instructs the mother "to take a deep breath and then *blow into a bottle* which causes pressure on the fundus and tends to produce strong uterine contractions" (Kitzinger 1982).

TBAs in West Amazonas [Jivaro people] try to stop a postpartum haemorrhage by applying *a stone (which has been warmed) against the vulva* (Kuntner 1988).

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* It has been added that "this may stimulate the uterus to contract and, in fact, be similar to a manoeuvre referred to in modern textbooks" (Berggren et al. 1983).

TBAs in Haiti (in Jacmel area) may treat postpartum haemorrhage with *herbs, herbal teas or massage* (Berggren et al.1983), and TBAs in Guatemala [people: Maya Indians; Ladinos] may recommend to drink a herbal tea (see Table 2.4.5.4) (Cosminsky 1982b).

2.4.5 The postnatal period *(physiological)*

2.4.5.1 CUTTING OF THE UMBILICAL CORD
Here we describe successively: *how, at what distance from the umbilicus* and *when* TBAs cut the umbilical cord.

2.4.5.1a *How do TBAs cut the umbilical cord?*
TBAs cut the umbilical cord with various *sharp tools* which are summarized in Table 2.4.5.1a
In Mexico they tie the umbilical cord first and then they cut it with a pair of scissors which has been cleaned with water(Jordan 1983), while in Jamaica the cord is often severed "with a dirty and rusty knife, frequently one which has been used for killing a chicken" (Kitzinger 1978 in Oudesluys-Murphy 1990). In Guatemala the cord is tied in two places and cut between (Cosminsky 1982b).

Table 2.4.5.1a Instruments to cut the umbilical cord used by TBAs in Latin America

Country	Instrument
Colombia Ecuador Haiti Jamaica Mexico	knife
Ecuador Haiti	razor blade
Ecuador Guatemala Haiti Mexico	scissors
Ecuador	sharp-edged plant ('sigse')
Haiti	piece of glass

Sources: Baquero et al. 1981; Berggren et al. 1983; Cosminsky 1982b; Durenkamp 1970; Jordan 1983; Kitzinger 1978 in Oudesluys-Murphy 1990; Priya 1992; Smits 1992/personal communication

2.4.5.1b *At what distance from the umbilicus do TBAs cut the cord?*
In Ecuador the umbilical cord is *left long*. The criteria for deciding where to cut the cord vary with the traditions of each community: for example, a 3-finger length is measured for boy babies [as "it is believed that anything over this length

will make the baby grow up to be an immoral person"], a hand's breadth for girl babies ["any shorter, and the girl will be too narrow in the hips"] or a 'geme' which is the distance from the tip of the outstretched thumb to that of the index finger (about 12-15 cm) for both boys and girls ["with less than this length a girl might have a small uterus"] (Baquero et al. 1981). In Colombia (in Nariño) the cord of a boy is left longer than that of a girl; it is believed that the long cord of the boy will make him strong in the future (Durenkamp 1970).
In Guatemala the cord is measured the width of 4 fingers taken from the base of the child's umbilicus (Cosminsky 1982b).

2.4.5.1c *When do TBAs cut the umbilical cord?*
TBAs in Jamaica and Mexico [Maya people] may cut the cord as soon *as it has stopped pulsating.* In Jamaica they do this often, in Mexico sometimes *after the birth of the placenta* (Jordan 1983; Kitzinger 1982). TBAs in Guatemala and in many other parts of Latin America cut the cord only after the birth of the placenta as it is believed that the child might die and the placenta might rise up in the mother's body and cause her to choke (Cosminsky 1982b; Priya 1992).

2.4.5.2 DRESSING OF THE UMBILICAL CORD
TBAs may dress the umbilical cord with any of the following: *fat, oil, ointment, ground nutmeg etc.* The dressings used by TBAs are summarized in Table 2.4.5.2

Table 2.4.5.2 Dressings of the umbilical cord used by TBAs in Latin America

Country	Dressing
Colombia	alcohol
Guatemala [Maya; Ladinos people]	"
Mexico [Maya people]	"
Colombia	fat (often tallow); oil; sawdust; cobweb; iodine; in hot ashes scorched cloth; a mixture of cocoa, oil and tallow; nothing
Ecuador	ointment or petroleum jelly (Vaseline)
Guatemala [Maya; Ladinos people]	cauterised with a candle flame
Haiti	powdered or crushed charcoal; burned strands of straw; sawdust; candle grease; nutmeg; pork fat; baby powder; cosmetic powder; indigo; sand; fresh earth; sugarcane syrup; plantain; starch; dust and water; ginger; red pepper; oil
Jamaica	ground nutmeg with talcum powder
Mexico	cauterised with three burning sticks

Sources: Balleur 1970; Baquero et al. 1981; Berggren et al. 1983; Cosminsky 1982b; Durenkamp 1970; Jordan 1983; Kitzinger 1982; Priester 1970; Priya 1992; Smits 1992, personal communication

TBAs in Ecuador may dress the cord with ointment or Vaseline and a clean cloth which is held in place with a navel bandage; in Jamaica TBAs treat the cord stump with ground nutmeg mixed with talcum powder and put a binder on (Baquero et al. 1981; Kitzinger 1982).
TBAs in Guatemala *cauterise* the end of the cord *in a candle-flame** and may also use alcohol to dress it (Cosminsky 1982b; MacCormack 1982). Cobweb is used by TBAs in Colombia (in Nariño) in order to let the cord dry very fast. As soon as the cord has dropped it will be greased with butter or margarine (Durenkamp 1970). In Mexico [Maya people] the infant is powdered by the TBA whereupon she "packs cotton balls soaked in alcohol around the navel stump and wraps a navel binder around its middle" (Jordan 1983).

2.4.5.3 Care of the infant

Immediately after birth the TBA in Mexico [Maya] *sucks the mucus out* of the infant's mouth and nose. Then she puts the infant on the mother's abdomen. After the birth of the placenta and after care of the mother the TBA *checks the infant's head, hands, feet and bottom.* Then she bathes it (Jordan 1983).

The infant is *bathed* by TBAs in Colombia, Ecuador, Jamaica and Mexico [Maya people] (Baquero et al.1981; Jordan 1983; Kitzinger 1982; Nadig 1990 in Kroeber 1990; Smits 1992, personal communication). TBAs in Ecuador wash the infant in lukewarm water (Baquero et al. 1981), while TBAs in Jamaica wash it in cold water with washing blue in order to keep away the 'duppies' [= evil spirits] (Kitzinger 1978/1982). In Mexico [Maya people] the infant is bathed with Palmolive soap as this soap contains oil (Jordan 1983).

After bathing the TBA in Jamaica may *massage* the infant with coconut or olive oil (Kitzinger 1982). In Mexico [Maya people] a TBA puts *drops into its eyes* (see also 2.2.5.3). In addition the baby is dressed. "If the baby is a girl the TBA will pierce her ears now: she dips a threaded needle in alcohol, and draws it through each ear; then she cuts the thread and ties it in a loop. The TBA will be back to check on the mother and child a day or so after birth. She gives the baby a sponge bath, either with warm water or with oil and she replaces the alcohol-soaked cotton balls around the navel stump" (Jordan 1983). TBAs in Colombia may put a few drops of lemon juice into the infant's eyes (Smits 1992, personal communication).

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* Cosminsky (1982b) reports about the practice of cauterizing the cord with a candle flame: "Since the cord is left dry and sterile, it is said to have been a factor to the low rate of tetanus in some parts of Guatemala. This practice is condemned by the medical personnel, who teach the TBAs to use either alcohol, iodine or Merthiolate on the cord instead. When I asked one nurse what was harmful about burning the cord, she said the candle might be dirty or drip and burn the baby. However, alcohol is believed to leave the wound damp and since the wound is then covered with a cloth dressing, there may be a chance of infection, unless special care is taken to check and change the dressing frequently. Some TBAs do not take chances and use both methods – cauterizing and alcohol – in adapting their practice to the new demands."

2.4.5.4 CARE OF THE MOTHER AFTER DELIVERY

TBAs in Guatemala [people: Maya Indians; Ladinos], Jamaica and Mexico [Maya people] *clean the mother's vulva with hot water* (Cosminsky 1982b; Jordan 1983; Kitzinger 1982; Nadig 1990 in Kroeber 1990). In Jamaica the mother is requested to squat over a bucket of steaming water ["hot like nine days love"] (Kitzinger 1982). Heat is frequently applied in Guatemala either in the form of sweatbaths [Maya people] or a hip bath ('bajo') [people: Ladinos], or a herbal bath (see Table 2.4.5.4). It is believed that the heat helps restore the woman's bodily balance, heal the woman, stimulate the nursing function, ease afterbirth pains and cleanse the woman.

Sometimes women are massaged during the sweatbath. In addition "some TBAs not only massage the abdominal area, but also the legs and thighs, lifting them up and rubbing them toward the pelvis; this is believed to prevent problems with their veins" (Cosminsky 1982b). The TBA in Mexico "sponges the mother off with hot water and packs cotton between her legs". [Thereupon she is dressed and after she has returned into her hammock she is covered with a blanket] (Jordan 1983). Mothers in Colombia are bathed by TBAs in herbal lukewarm water (e.g. camomile, marjoram, rosemary); bathing may be performed only a few days after birth (Smits 1992, personal communication).

In Haiti, Jamaica and Mexico [Maya people] the mother is *kept indoors* (see also 2.2.5.4/ 2.3.5.4). From Haiti it has been indicated that "smoke from a fire must ascend in front of the closed doorway behind which mother and baby must stay in the dark for at least a week" (Berggren et al. 1983). In Jamaica mother and child have to remain inside at least for 9 days [a less restricted period of seclusion is supposed to last for 40 days from delivery], in Mexico 7 days (Jordan 1983; Kitzinger 1978/1982). The argument for keeping mother (and child) inside is that they are considered to be extremely vulnerable to the influence of spirits of the bush; the spirits in Jamaica ('duppies') may come and get the child (Jordan 1983; Kitzinger 1978). Nadig (1990) reports from Mexico [Maya people] that the mother has to stay indoors for a few weeks in order to protect herself against "the spirits of the dead, angry winds and bad influences from people". For 7 days she has to stay in a room at the back of the house; after that she can move through the whole house, but only after two weeks she is allowed to go into the kitchen and the garden. After about one month the period of seclusion is over. Priester (1970) has indicated that mothers in Colombia (in Nariño) stick to a restricted period of 40 days after birth which is called 'dieta'; during this period they are neither allowed to travel, to bath themselves and to eat all kinds of food. In Guatemala [people: Maya; Ladinos] mothers also stick to a restricted period of 40 days, which is called 'cuarentena'. According to a TBA: "after 5 days a mother can go out, but not work. After 10 days she can work a little, but not much, depending on her nutrition and strenght. After 20 days she can work, but not very heavy work, and after 25 days, she can do everything including washing clothes. However, she should not have sexual relations nor can she enter the church for 40 days after birth." During this period dietary restrictions have to be followed too (see 3.4.2.3)(Cosminsky 1982b).

TBAs in Colombia, Guatemala [people: Maya; Ladinos] and Mexico perform *massage and tying* of the abdomen in the postnatal period (Cosminsky 1982b; Durenkamp 1970; Jordan 1983/ 1989; Nadig 1990 in Kroeber 1990; Smits 1992, personal communication). Twenty days after birth the TBA in Mexico [Maya people] will administer massage similar to the prenatal massage (see 2.4.1.1), which is completed by tying the woman's belly with a cloth. Jordan (1983) gives a description of this massage: "the TBA together with another woman wrap a six-inch strip of cotton cloth around the woman's abdomen, beginning in front and passing the ends to each other under the woman's buttocks. Everytime the bandage is passed, they each brace one foot against the woman's hip and pull, thereby tightening the girdle as tight as the woman can stand it. After about three passes, the ends are knotted several times." In addition the author states that frequently a woman's breasts and head are also tied. TBAs in Guatemala massage "toward the center of the abdominal area, pushing up from below the abdomen and down from the chest; this is to make the womb return to its proper size and place and to relieve postpartum pains. After the massage, an abdominal binder is tied below the navel, pushing the abdomen upward. The binder is supposed to keep the 'matriz' or uterus in place and to close the bones, which are believed to have opened at the time of the birth." (Cosminsky 1982b). In Colombia (in Nariño) TBAs administer massage with 'Belladonna' ointment and may tie the mother with a rope directly under the ribs (in order to prevent the uterus rising in the body), with 'fajas' (bandages) and a folded sheet. Before tying the abdomen may be covered either with a thin paper with oil or with 'Chilanquan' leaves (Durenkamp 1970; Smits 1992, personal communication).

In Colombia (in Nariño) TBAs may *provide herbs* which have to be taken orally. A purgative called 'Borraja' is given in order to stimulate the secretion of breast milk. Other mentioned herbs are: 'Culantrillo', 'Aracacha', 'Amapolas' and 'Voraja'. Cosminsky (1982b) indicates that TBAs in Guatemala [people: Maya Indians; Ladinos] may administer herbal teas.

A summary of the different treatments TBAs in Guatemala may perform is given in Table 2.4.5.4.

2.4.5.5 Care of the placenta

The TBA in Mexico [Maya people] will show the placenta to the mother and examine it to make sure that it is complete. The placenta is thought of as the 'companion' of the infant; it is believed that how it is treated influences the health of the infant. It is the father who has to *bury* the placenta in an appropriate place in order to avoid any harm to his newborn child (Jordan 1983/1989). In Haiti the placenta has to be buried underneath the doorway of the house in which the birth took place (Berggren et al. 1983). In Guatemala [people: Maya; Ladinos] the placenta is *burnt* and the ashes buried; like in Mexico it is also believed that the placenta has a special relationship to the child (the 'second child') and that proper disposal is necessary (see also 2.2.5.5/2.3.5.5). [Proper disposal of the cord is important too. According to a TBA "the cord should be put in a covered jar and saved. It may be used as a remedy for barren women. If the infant is a male, the cord may be put in a tree; if a female, it may be put under the hearth".] (Cosminsky 1982b).

Table 2.4.5.4 Care of the mother in the postnatal period in Guatemala

Treatments	Intentions
Massaging the abdomen	Making the womb return to its proper size and place
Tying an abdominal binder below the navel	Keeping the uterus in place and closing the bones
Massaging the legs and thighs, lifting them up and rubbing them toward the pelvis	Preventing problems with veins
Massaging the abdomen Drinking herbal teas: – tea of 'pimpinela', white honey and oregano – tea of artemis	Relieving afterbirth pains
Applying a sweatbath or a sitz bath: – bath of hot water with Santa Maria (*Piper* sp.), 'guaruma' (*Cercopia peltata)*, 'ciguapate' (*Pluchea odorata)*, and 'siquinai' (*Vernonia* sp.), on the third day and eighth day – sitz bath ('bajo'): sitting over bucket of hot water containing tips of peach tree, cherry tree, 'espina valudo wachulin' (*Lechina caulescens)*, 'lanten' (*Plantago australis)* and 1/2 bottle of milk	Stimulating the nursing function
Drinking tea of artemis and 'pimpinela'	Treating haemorrhage
Drinking tea of 'quequexte' (*Xanthosoma robustum)* Heating 'alhucema' (lavendar), putting a cloth in the smoke and placing on front and back of chest	Increasing breast milk
Drinking tea of oregano, 'alhucema', cumin, 'salvia santa', cinnamon, 'pimienta de castilla', 'balsamito de aire' with 1/2 bottle of white honey and 1/4 octavo of rum	Treating fallen uterus

Source: Cosminsky 1982b

2.4.6 The postnatal period *(pathological)*

2.4.6.1 IMMEDIATE CARE OF THE ASPHYXIATED NEWBORN

When the infant does not breathe immediately after birth TBAs in Ecuador *fan* it with a cloth and *slap* on its buttocks and chest (Baquero et al. 1981). TBAs in Jamaica may *hold the newborn upside down* while "'milking' mucus from the nose by pinching the nostrils and blowing cigarette smoke on to its anterior fontanelle ['mole']" (Kitzinger 1982).

2.5 Discussion

In this review of the literature concerning practices and beliefs of TBAs we have tried to get a balance between the number of descriptions in the three continents Africa, Asia and Latin America. We realize, however, that this investigation will

never be complete. Descriptions of the practices and beliefs of TBAs are usually based on interviewing TBAs and sometimes on observations of deliveries assisted by TBAs (among others Blanchet 1984; Cosminsky 1982; Jordan 1983; Laderman 1982). During interviews it is possible that TBAs talk about their practices in a way they hope to please the interviewer, nevertheless it still may be useful information as it is the most extensive information we have.

Comparison of the practices and beliefs of TBAs in *Africa, Asia and Latin America* has revealed great variety according to the different cultures in the three continents. However, it is surprising that there are obviously common practices or beliefs in all three continents such as an upright position of the woman during the second stage of labour (intrapartum period), lubricating the perineum with oil as a preparation of the birth canal (intrapartum period), leaving the umbilical cord long while cutting (postnatal period), and after the birth of the placenta providing the mother with warmth and/or smoke (see Table 2.5a). These common practices are presumably due to the expression people give in the same way to the basic events of life as pregnancy and labour.

Comparison of the practices and beliefs of TBAs in *Africa and Asia* has revealed other strikingly common practices and beliefs such as imposing the same kind of taboos on activities with similar arguments during pregnancy (antenatal period), manual removal of a retained placenta, or believing that postpartum haemorrhage is not alarming as it is considered to be a flow of 'bad' [= menstrual; YL] blood (intrapartum period), cutting the umbilical cord at the lenght of where it reaches the knees or head of the child while believing that passing the genitals should be avoided in order to prevent the child becoming infertile, stretching the limbs of the newborn, or milking the umbilical cord as immediate care of the asphyxiated newborn (postnatal period) (see Table 2.5b).

Comparison of the practices and beliefs of TBAs in *Asia and Latin America* has revealed that only one practice seems to be common. As part of the 'immediate preparation' [intrapartum period/first stage] measures are taken to prevent a possible attack of evil spirits to the house in which the delivery will take place. In Latin America doors of the house of the woman in labour are kept shut, while in Asia a spiny pineapple or screw pine is placed underneath the house and a mixture of salt, rice and tamarind is thrown around the house.

Comparison of the practices and beliefs of TBAs in *Africa and Latin America* has revealed again common practices such as blowing into a bottle or gourd, inserting something into the throat as a vomiting method, placing heated brandy near the vagina (or fumigation) in the case of a retained placenta (intrapartum period), cutting the umbilical cord once it has stopped pulsating, and putting a hot compress or blowing smoke on the anterior fontanelle as immediate care of the asphyxiated newborn (postnatal period)(see Table 2.5c).

There are also differences as there are practices which seem to occur in the countries of *one* continent only. For example, in Africa performance of an episiotomy in the case of either a breech presentation or a prolonged labour, or internal version in the case of a prolonged labour. Cauterising the umbilical cord in a candle flame has been explicitly reported from Latin America. Trampling on the placenta and /or roasting it as immediate care of the asphyxiated newborn, and preparing offerings for ceremonies or rituals during the course of pregnancy have been reported in Asia only.

Table 2.5a Common practices or beliefs of TBAs in Africa, Asia and Latin America

Obstetrical neonatal situation	Practices and beliefs
Antenatal period (*physiological*)	
Prenatal care	promoting adherence to taboos massage of the abdomen
Antenatal period (*pathological*)	
Breech presentation	external version
Intrapartum period (*physiological*)	
First stage	
Physical examination	vaginal examination
Coaching the woman in labour	encouraging to walk around during early labour giving herbal medicines massage of the abdomen
Second stage	
Position of the woman	upright position
Preparation birth canal/ Support of the perineum	lubricating the perineum with oil pressing something against the perineum to support it
Third stage	
Birth of placenta	massage of the abdomen
Intrapartum period (*pathological*)	
First stage	
Prolonged labour	rubbing herbs on the abdomen vomiting method urging the woman to confess unfaithfulness/guilt
Third stage	
Retained placenta	massage of the abdomen vomiting method
Postnatal period (*physiological*)	
Cutting of the umbilical cord	
– how –	with (mostly unsterilized) razor blade, scissors, knife, grass etc.
– at what distance from the umbilicus –	the cord is left long
– when –	after the birth of the placenta
Dressing of the umbilical cord	with fat, ashes, powder, leaves etc.
Care of the infant	bathing, and wrapping in a cloth keeping indoors
Care of the mother	bathing giving herbs massage and tying of the abdomen keeping indoors (varying from 8-40 days) providing warmth and/or smoke
Care of the placenta	burying, or burning
Postnatal period (*pathological*)	
Immediate care of the asphyxiated newborn	slapping on buttocks, or on back

Table 2.5b Common practices or beliefs of TBAs in Africa and Asia only*

Obstetrical neonatal situation	Practices and beliefs
Antenatal period *(physiological)*	
Prenatal care	imposing similar taboos on activities during pregnancy with similar arguments: – standing in the doorway (*may cause obstructed labour)* – going for a walk and returning halfway (*may cause prolonged labour*) – bathing late in the morning, afternoon or at night, or walking at night (*may draw evil spirits*) – sleeping during daylight, or being lazy (*may cause a long delivery as the child may behave in the same way on its delivery day)*
Antenatal period *(pathological)*	
Intrauterine death	administering herbs orally
Intrapartum period *(physiological)* ***First stage***	
Immediate preparation	preparing very little or nothing
Physical examination	external examination
Intrapartum period *(pathological)* ***Third stage***	
Retained placenta	manual removal administering herbs orally
Postpartum haemorrhage	believing flow of 'bad' blood not to be alarming
Postnatal period *(physiological)*	
Care of the infant	stretching infant's limbs
Care of the placenta	sinking in a river
Postnatal period *(pathological)*	
Cutting of the umbilical cord – at what distance from the umbilicus	– cutting at the lenght of where the cord reaches the knees or the head of the child while believing that passing the genitals should be avoided in order to prevent the child becoming infertile
Immediate care of the asphyxiated newborn	milking the umbilical cord sneezing method (by putting something near or in the nose) making noise

* Practices or beliefs common in the three continents are not repeated again (see Table 2.5a)

Table 2.5c Common practices or beliefs of TBAs in Africa and Latin America only*

Obstetrical neonatal situation	Practices and beliefs
Antenatal period *(physiological)*	
Prenatal care	providing herbal medicines
Antenatal period *(pathological)*	
Transverse presentation	external version
Intrapartum period *(physiological)*	
Second stage	
Position of the mother	(semi) recumbent position
Third stage	
Birth of the placenta	blowing into bottle
Intrapartum period *(pathological)*	
First stage	
Prolonged labour	administering herbs orally
Management breech presentation	allowing baby's body to hang by its own weight, and doing nothing
Third stage	
Retained placenta	blowing into gourd/bottle vomiting method (by inserting something into throat) fumigation/placing heated brandy near the vagina
Postnatal period *(physiological)*	
Cutting of the umbilical cord – when –	once it has stopped pulsating
Care of the infant	sucking the mucus out putting drops into the eyes
Postnatal period *(pathological)*	
Immediate care of the asphyxiated newborn	blowing air on newborn's face holding the newborn upside down hot compress/blowing smoke, on the anterior fontanelle

* Practices or beliefs common in the three continents are not repeated again (see Table 2.5a)

3 Dietary Advice by Traditional Birth Attendants During Pregnancy and Lactation

3.1 Introduction

Part of the birthing practices of TBAs includes giving foodrecommendations and/or promoting adherence to dietary restrictions during pregnancy and during the period immediately after birth. Larsen et al.(1983a) have, for instance, reported from South Africa [Zulu people] that TBAs "understand their role during the phase of pregnancy to be that of a health educator" and their advice includes dietary taboos.
People need a balance of different nutritious foods for each period of life. As food taboos and/or recommendations may lead to a deficiency of nutrients which are essential for the health of women and infants a description of the restricted and/or recommended foods for women and infants of the three continents Africa, Asia and Latin America is given from the available literature. The traditional food habits of the pregnant and lactating woman and her outcome are presented for the antenatal and the postnatal period. The foods are presented as much as possible according to the Nutritional Classification 'Basic Food Plan', which is used for Health Education in tropical countries (Hiel et al. 1984). In this 'Basic Food Plan' every day food is classified as foods for growth, protective foods, energy producing foods and water (Figure 3.1).

3.2 Africa

3.2.1 The antenatal period

3.2.1.1 Foodtaboos for the pregnant woman

It is generally believed that antenatal foodtaboos prevent the birth of a baby who is too large and hence a difficult delivery. Reports from South Africa [Pedi; Shona; Zulu people] indicate that antenatal food restrictions of as much as a third to a half of the mother's normal intake have been traditionally imposed in order to prevent a big child and subsequently a difficult delivery (Mphahlele 1982; Stein & Mouton 1979; Stewart, Cowan and Philpott 1979 in Chalmers 1990). Something similar is found in other African countries such as Kenya [Digo people], Somalia and Zambia [Tonga people] where foodrestriction, especially of staple-food during the last three months of pregnancy is advised to prevent the child becoming too big (Le Nobel 1969; Solomon/Rogo 1989; Voorhoeve 1992, personal communication). But the fear of a too large baby is not the only argument for foodtaboos

Figure 3.1 Nutritional Classification 'Basic Food Plan'

Foods for Growth	Protective Foods
fish chicken; meat eggs milk (ground) nuts grain legumes	vegetables (green leaves, tomatoes, carrots, beans etc.) fruits (oranges, pawpaw, pineapple, mango etc.)
nutrient: protein	*nutrients: vitamins* *minerals*

Energy Producing Foods + Water

staple-foods
(yam, millet, rice, maize,
cassava, plantain etc.)
fats and oils
sugars

nutrients: carbohydrates
fats

Sources: Hiel et al. 1984; King et al. 1972; McWilliams 1975

during pregnancy. There are more reasons why people believe that certain kinds of food have to be restricted in the antenatal period (Table 3.2.1.1a, Table 3.2.1.1b and Table 3.2.1.1c).

Additional foodrestrictions during pregnancy include foodstuffs like *herbs* (e.g. pepper) [in Kenya [Akamba people]: herbs may damage the child's eye/in Senegal [Diola people]: 'hot' herbs may cause squinting of the child's eyes], *alcoholic drinks* [in Kenya [Akamba people], South Africa [Zulu people] or Senegal [Diola people]: alcohol may cause severe haemorrhage during delivery], *coconut milk* [in Sierra Leone [Mende people]: the milk may cause postpartum haemorrhage] or *hot food* [in Kenya [Akamba people]: too warm food may cause burning of the child and the forming of mongolian spots* on the child's buttocks] (Korfker 1983; Larsen et al. 1983a; Rebel 1988; West 1981).
Akenzua et al. (1981) report from Nigeria [Edo people] that there is *no* taboo against any local food during pregnancy; this contrasts with the findings in other parts of the country.

* 'Mongolian spots' are blue-back patches on the back, buttocks, or thighs. They occur in most dark-skinned populations. They usually disappear as the child grows older (Lawson/Stewart 1970).

Table 3.2.1.1a Taboos on Foods for Growth during pregnancy in Africa

Kind of Food	Country	People	Argument
Eggs			
	Kenya	Digo	may cause baldness in the newborn
too many eggs	Kenya	Akamba	unknown
	Nigeria	Yoruba	the infant may be born with a bald head
	Sierra Leone	Mende	may cause neonatal asphyxia and various other problems, as the egg is the unborn child of the chicken, which is a sacred bird for the Mende; therefore, counter-attack may be taken on one's own child
	South Africa	Sotho; Zulu;	may cause abortion or a delayed or obstructed
		Xhosa	labour; may also cause increased sexual arousel
	Tanzania	Wahehe	unknown
		Waluguru	may cause a stillborn child
		Wasagara	may cause a very difficult delivery and a retained placenta
	Zambia	Lozi; Mbunda	may cause a child born with a caul
Fish	Sierra Leone	Mende	may cause worms in newborn babies and pregnant women, which may result in an 'unclean stomach' and diarrhoea
'electric fish' [*Gymnarchus niloticus*]	"	"	may cause tetanus in the new-born child
fresh fish	Tanzania	Wanyakyusa	unknown
red bream*	Zambia	Lozi; Mbunda	may cause bleeding during pregnancy
Legumes			
cow peas	Tanzania	Waluguru	may cause the birth of a very small and slowly growing child or an abortion
black peas		Wachaga	may cause a child suffering from a disease
Meat			
much fat meat	Kenya	Akamba	may cause the formation of a white layer which covers the child's skin
	South Africa	Sotho; Zulu; Xhosa	may cause abortion or delayed or obstructed labour
guineafowl	"	Zulu	may cause a child with a head like a bird
goat	Tanzania	Wahehe	unknown
meat from pregnant animals	"	Waluguru	may cause a stillborn child

Table 3.2.1.1a Continuation

Kind of Food	Country	People	Argument
Meat			
eland	Tanzania	Waluguru	may cause a child with generalised swellings on its body and a retained placenta
liver	Zambia	Lozi; Mbunda	may cause severe haemorrhage during delivery
locusts	"	Tonga	may cause genital malformations in the child
hare	"	"	may cause a hare-lip in the child or a child who is too intelligent so that it has no respect for the parents
Milk	Senegal	Diola	may cause a big child and subsequently a difficult delivery
	South Africa	Sotho; Zulu; Xhosa	may cause abortion or a delayed or obstructed labour
	Tanzania	Wachaga	unknown
Poultry	Tanzania	Wanyakyusa	unknown
	Zambia	Tonga	may cause crying of the infant

* red bream = type of a freshwater fish of the carp family
Sources: Chalmers 1990; van Ginneken et al. 1984; Korfker 1983; Larsen et al. 1983a; Le Nobel 1969; van Luijk 1982; MacCormack 1982; Moller 1961; Ntoane 1987; Rebel 1988; Schneider 1985; Solomon/Rogo 1989; Voorhoeve 1991, personal communication; West 1981; van Zanden 1988

Table 3.2.1.1b Taboos on protective foods during pregnancy in Africa

Kind of food	Country	People	Argument
Vegetables			
bitter and sour vegetables	Nigeria	Hausa	may cause an abortion
beans and other vine plants	Sierra Leone	Mende	may cause strangulation by the cord
egg plant	Sierra Leone	Mende	may cause thrush or skin disease in the newborn
	South Africa	Venda; Bomvana	unknown
Fruits			
bananas	Kenya	Akamba	may cause the forming of a white layer which covers the child's skin
sweet fruits	Nigeria	Hausa	may cause a long and painful delivery
bitter and sour fruits	"	"	may cause an abortion
twin bananas [= 2 bananas grown together]	Tanzania	Waluguru	may cause the birth of twins which is a serious misfortune
lemon or monkey bread	Senegal	Diola	may cause peeling of the child's skin

Sources: Fleischer 1990; van Ginneken et al. 1984; Korfker 1983; van Luijk 1982; Moller 1961; Rebel 1988; Tyrrell & Jurgens 1983; West 1981

Table 3.2.1.1c Taboos on energy producing foods and water during pregnancy in Africa

Kind of food	Country	People	Argument
Staple-foods			
maize porridge	Kenya	Digo	may cause a big child and subsequently a difficult delivery
maize & beans	Kenya	Akamba	unknown
millet [uncooked & prepared with milk or water]	"	"	"
bread or cake	Senegal	Diola	may cause a big child and subsequently a difficult delivery
cassava	Sierra Leone	Mende	may cause the cord stump to take too long to drop off
plantain	"	"	may cause prolapsed cord, sunken fontanelle, retained placenta, and constipation in the mother
Fats and oils			
	Kenya	Akamba	may cause the child to grow too big
	Tanzania	Wachaga	"
	Zimbabwe	Shona	may cause excessive amounts of vernix caseosa in utero, and may thus cause delayed drying and dropping of the umbilical cord stump after delivery
Sugars			
honey	Kenya	Akamba	may cause postpartum pain
	Nigeria	Hausa	may cause a longer and more painful delivery
	Senegal	Diola	may cause mongolian spots* on the child
	Tanzania	Wahehe	unknown
Water			
much water	Tanzania	Wachaga	unknown

* See footnote p. 79

Sources: van Ginneken et al. 1984; Ityavyar 1984; Korfker 1983; van Luijk 1982; Moller 1961; Mutambirwa 1985; Rebel 1988; Solomon/Rogo 1989; West 1981

3.2.1.2 Foodrecommendations for the pregnant woman

Pregnant Hausa women in Nigeria are recommended to eat liver, palmoil and green leafy vegetables in order to get more blood. From the seventh month of pregnancy they should take medicines like extracts from the Bambara groundnut [*Voandzeia subterranea*] in order to urinate more (Fleischer 1990). Pregnant women in Zimbabwe are encouraged to eat green leafy vegetables, especially pumpkin leaves. In addition vegetables "high in mucin content" such as okra are encouraged as it is believed that they "increase laxity of the vaginal mucosa thus facilitating easy delivery". Porridge made out of 'rappoko' flour is recommended because it is said to be "more nutritious, digestible and thus reduces tendencies to develop heartburn." (Mutambirwa 1985)

3.2.2 The postnatal period

3.2.2.1 FOOD FOR THE NEWBORN

In most countries of Africa the newborn is fed by *breastfeeding*. A very first food may be given to the newborn before putting it to the breast: in Ghana [Asante people], for instance, a few sips of *gin or rum or lime-juice* are given to 'clear' the baby's throat. Among the Tallensis in Ghana, some of the very hot *herbal water* used to bath infants may also be given (Kaye 1962). In Nigeria [Yoruba people] a newborn is given some sips of *palm wine* (Voorhoeve 1992, personal communication).

These very first foods are believed to be very important and are highly symbolic (see also 3.3.2.1). Breastfeeding may be given immediately after birth but when the *colostrum** is considered unhealthy one waits a day, or a few days while in the meantime *water or water with sugar* is given. It is interesting to note whether the colostrum is discarded or not. From South Africa [Pedi; Southern Sotho; Zulu people], Zambia [Mbunda people] and Zimbabwe it has been reported that TBAs encourage breast-feeding, but mothers express the colostrum from their breasts (and discard it) for the first 24 hours (or longer) before breastfeeding: the newborn is instead fed a *watery porridge* (South Africa) [Pedi; Southern Sotho people], a mixture of *sugar and water* or the *milk of a newly delivered cow* [Zulu people], *water* and very *light beer* ['*mahel*'] (Zambia) or *boiled water with a bit of sugar* (Zimbabwe)(Adams 1980; Brindley 1985; Jurgens 1983; Larsen et al. 1983a; Mapondera 1989; Tyrrell & Schneider 1985; van Zanden 1988). TBAs in South Africa [Zulu people] give advice about breast-feeding. They recommend throwing away the colostrum and instead giving a mixture of sugar and water to clear the infants' bowel of meconium (Larsen et al. 1983a). TBAs in Nigeria [Edo people] also advise mothers to discard the colostrum (Akenzua et al. 1981). Shona mothers in Zimbabwe discard the colostrum as they believe that it "induces meconium purging which is associated with baby's abdominal discomfort" (Mutambirwa 1985). Jepson/MacDonald (1988) report from South Africa [Zulu people] that TBAs who consider the colostrum to be harmful quite differently advise about breastfeeding: some TBAs may prescribe a *dextrose/water mixture* to be used on the first day and permit breastfeeding on the second, others may forbid breastfeeding until after the second day while TBAs may also recommend *diluted cow's milk* until breastfeeding is commenced on the second or third day; some TBAs may allow breastfeeding to start at once, while others give undiluted cow's milk on the first day and permit breastfeeding from the second. Boersma (1979) reports from Tanzania that *water with or without sugar* is sometimes given *in addition to colostrum:* "Immediately the child is born it is placed on the breast and induced to suck. .... During the first few days when the colostrum is not enough most mothers in addition give their children plain water, water with cane sugar and some add a little bit of salt to the water."

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* Colostrum = the first breast milk which is yellowish and sticky. The colostrum is rich in many nutrients and also anti-infective factors which protect the infant from infections (Cameron/Hofvander 1983).

From Nigeria [Hausa people] it has been reported that before the baby takes the mother's milk, the TBA will "test the milk by pouring it on hot metal. If it coagulates on the hot metal, it means the milk is not good for the baby and other feeding methods are then arranged" (Ityavyar 1984).

3.2.2.2 FOOD FOR THE MOTHER

Mothers in Kenya, Senegal, South Africa and Tanzania are often given *porridge* immediately after birth; this porridge is usually prepared from the staple-food which is consumed daily, but may be restricted during the last months of pregnancy (see 3.2.1.1)(Boersma 1979; Jepson/MacDonald 1988; Korfker 1983; Moller 1961; Rebel 1988). In Kenya [Akamba people] mothers are given a lot of warm *millet* porridge which is believed to induce breastfeeding (Rebel 1988). In Senegal mothers are given *rice* porridge made of rice with a lot of water and sugar (Korfker 1983). Mothers in Tanzania [Waluguru people] are given a thin porridge of *maize* flour or *cassava* ['uji'] with herbs ['dawa'] (Moller 1961).
Boersma (1979) reports from Tanzania that mothers "are fed on the same diet as that of other adults sometimes with extra milk" and "the food is made a little softer for it is believed 'hard' food stops milk production".
During a period of two months after delivery mothers of the Wachaga people in Tanzania are kept on a 'rich' diet with plenty of *milk, meat, blood and oil* (Moller 1961).
As a cure for poor lactation mothers of the Shona people in Zimbabwe are "induced to take copious fluids by eating *well-salted round nuts* which are roasted over a fire" (Mutambirwa 1985).

3.2.2.3 FOODTABOOS FOR THE LACTATING WOMAN

In Tanzania [Wahehe people] a lactating woman is not allowed to eat *chicken,* which is supposed to cause fever and convulsions in the child (Moller 1961).

3.3 Asia

3.3.1 The antenatal period

3.3.1.1 FOODTABOOS FOR THE PREGNANT WOMAN

In several areas in Asia people may divide food into different categories such as 'hot' and 'cold', 'wet' and 'dry', 'hard' and 'soft'. Foodstuffs are just figuratively classified in this way: pineapple for example is considered to be 'hot' in Indonesia. Foodrestrictions during pregnancy (and after delivery) often concern these categories. Lam (1991) reports from Indonesia (West Sumatra) [Minangkabau people] that TBAs advise pregnant women to eat little or no fish, ice or *'hot' foods* such as pineapple, peté, jengkol, or tapé.* Most TBAs "consider eating too much food classified as 'hot' during pregnancy dangerous for the fetus". In Madura in

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* *Peté* = pulse with a strong smell; *jengkol* = fruit with the size of a small apple; its green kernel, which has a strong smell, is often prepared as a vegetable; *tapé* = boiled, fermented cassava [root crop].

Indonesia 'hot' food and drinks are forbidden during the first months of pregnancy; as soon as the movements of the fetus are felt 'cool' food and drinks are preferred to those classified as 'hot' (Niehof 1988). In India (Andhra Pradesh) some pregnant women refuse to take eggs and meat believing that these are 'hot' foods (Karan et al. 1983). Dietary restrictions during pregnancy have also been reported in Bangladesh: especially restrictions of 'sour' or 'hot' foods, but also of fat foods, meat, honey, certain fish, pulses and other foodstuffs (Amin/Khan 1989). The restricted kinds of foods in Asia and the reason why people believe these have to be restricted during pregnancy are presented in Table 3.3.1.1a, Table 3.3.1.1b and Table 3.3.1.1c

Table 3.3.1.1a Taboos on Foods for Growth during pregnancy in Asia

Kind of Food	Country (Region)	Argument
Eggs	India (Andhra Pradesh)	unknown
Fish	Bangladesh	"
	Indonesia (West Sumatra)	may cause the child grow too big
fish eggs	"	may cause the birth of a child with spotty skin
	Irian Jaya	unknown
Legumes		
pulses	Bangladesh	"
Meat	Bangladesh	"
	India (Andhra Pradesh)	"

Sources: Amin/Khan 1989; Karan et al. 1983; Lam 1991; van Oosterhout 1993; Voorhoeve 1992, personal communication

Table 3.3.1.1b Taboos on Protective Foods during pregnancy in Asia

Kind of food	Country (Region)	Argument
Vegetables		
certain vegetables	Bangladesh	unknown
eggplant	Philippines (San Pablo)	may cause the birth of a blue child
Fruits		
pineapple; durian	Indonesia (West Sumatra)	may cause a miscarriage [pineapple/durian = 'hot' food]
twin bananas	Philippines (San Pablo)	may cause the birth of twins

Sources: Amin/Khan 1989; Lam 1991; Tuazon 1987

Table 3.3.1.1c Taboos on energy producing foods, and water during pregnancy in Asia

Kind of food	Country (Region)	Argument
Staple Foods		
wheat bread	Bangladesh	unknown
raw rice	Indonesia (West Sumatra)	may cause the child to grow too big
Fats and Oils	Bangladesh	unknown
	Indonesia (West Sumatra)	may cause the child to grow too big
Sugars		
honey or any sweet	Bangladesh	unknown
sweet foods	Philippines (San Pablo)	may cause the child to grow too big
soft drinks	"	may cause the birth of a child with a hard skull resulting in a difficult delivery

Sources: Amin/ Khan 1989; Lam 1991; Tuazon 1987

3.3.1.2 FOODRECOMMENDATIONS FOR THE PREGNANT WOMAN

In the Philippines pregnant women are recommended to eat *raw egg* just before actual delivery as the slimy consistency is believed to lubricate the birth canal (Tuazon 1987).

In Bangladesh pregnant women have few if any food restrictions during pregnancy (while after delivery they have to avoid 'hard', 'cold', 'wet' and 'sour' foods) (Blanchet 1984).

3.3.2 The postnatal period

3.3.2.1 FOOD FOR THE NEWBORN

In many places of Asia newborns are *breastfed* (Blanchet 1984; Lam 1991; van Oosterhout 1993; Priya 1992; Schiefenhövel 1982; Voorhoeve 1965; Weiss 1990 in Kroeber 1990). Often a very first food is given to the newborn before putting it to the breast; for instance, in Bangladesh a few drops of *mustard oil* are given to clean the intestine of meconium (as the meconium is believed to come from food taken inside the womb). This very first food is highly symbolic as its main purpose is to clean and purify the body and "initiate life with a taste of sweetness" (see also 3.2.2.1). After giving the mustard oil something sweet is put on the newborn's tongue, preferably *honey;* honey is a special food which Hindus offer to their gods and Muslims use for ritual and medicinal purposes. In the absence of honey other sweet foods are used such as sugar extracted from a palm tree ['tal misri'], home-made unrefined sugar ['gur'] or refined sugar mixed with a little water (Blanchet 1984). Two spoonfulls of *castor oil* which are given symbolically to newborns in Maharashtra [and sometimes in Andhra Pradesh (Karan et al.1983)] in India "in the belief that a catharsis is necessary to remove the fluids of the womb ingested by the newborn during birth" (Chand/Soni in Morley et al. 1983). Infants in Andhra Pradesh in India are usually given a *herbal preparation* made from locally available crushed leaves which are considered to possess laxative properties. "The

objective is to flush out the dirty meconium." (Karan et al. 1983). In the area of the Central Mountains of Irian Jaya people let the newborn lick on a piece of *pork fat* before putting it to the breast (Voorhoeve 1965). In Malaysia a small ceremony may be carried out when the infant is given the breast for the first time: the mouth of the newborn is touched with salt, gold and silver. The newborn of the Karen people in Thailand is given a few grains of *rice* in order to tell it that this is the food which it will get when it finishes breastfeeding (Priya 1992). In Indonesia (in West Sumatra) [Minangkabau people] the newborn is also given rice water (instead of the first breast milk) during the first days in order to learn the taste (van Oosterhout 1993). Weiss (1990) observed something similar in Papua New Guinea [Iatmul people] where people put a very small *piece of sago* on the infant's tongue in order to get the infant used to its taste.

Colostrum is discarded in Bangladesh, India (in Andhra Pradesh), Indonesia (in Madura en West Sumatra), Irian Jaya (in Waropen area) and the Philippines. The infant in Madura in Indonesia is given some honey or coconut water instead (Niehof 1988); and – as mentioned above – in West Sumatra [Minangkabau people] rice water (van Oosterhout 1993). Blanchet (1984) reports that the taboo of giving the colostrum is found all over Southeast Asia and is linked to the pollution of birth: yellowish and thick colostrum which is believed to have been stagnant in the breast for 10 lunar months is often associated with pus and considered impure. It should never be fed to a newborn who may start vomiting and producing liquid stools which may result in his death. Usually two and a half days after birth the newborn is put to the breast; meanwhile it is spoonfed with *cow's milk or water with 'tal misri'*, a sugar extracted from a palmtree. Another report from Bangladesh (Amin/Khan 1989) indicates that the time to initiate breastfeeding varies from within 3 hours of birth to more than 4 days. Using a data set collected from TBAs (n=242), who had been interviewed from a questionnaire, a percentage of their responses concerning the time of initiating breastfeeding is presented in Table 3.3.2.1.
This Table shows that more than half of the total number of TBAs (52.1%) indicate that breastfeeding has to be initiated within 2 days after birth.

Table 3.3.2.1 Percentage of the time taken to initiate breastfeeding as perceived by TBAs in Bangladesh (n =242)

Time to initiate breastfeeding	Percentage
Within 3 h of birth	11.2
4-6 h	16.9
7-12 h	9.5
After 1 day of birth	14.5
After 2 days of birth	17.3
After 3 days of birth	28.9
After 4 days of birth	1.7

Source: Amin/Khan 1989

In India (in Andhra Pradesh) the colostrum is rejected by mothers in the belief that it is harmful as it can cause indigestion in the infant. In addition it is considered to be pus and labelled 'cheemu palu'. Instead *honey or water* is given for the first two days, or a close relative or neighbour with a young baby is employed to breastfeed (Karan et al. 1983). Women in Irian Jaya (Waropen area) give the newborns a little *sago-porridge* instead of the colostrum. This porridge is not given as food supplementation but as a 'principle of life' (Oomen/ Malcolm 1958 in Voorhoeve 1965). Tuazon (1987) indicates that in the Philippines colostrum is not given to the newborn "because the yellowish colour is taken as a sign that the milk is spoiled".
Still, in other places of Irian Jaya [in the area of the Central Mountains; in the Jeei and in the Eipo society] newborns are given the colostrum (Schiefenhövel 1982; Veeger 1959 in Voorhoeve 1965). Mothers in the Central Mountains of Irian Jaya may *spit small pieces of chewed food* ('papeda') into the newborn's mouth besides the breastfeeding (Voorhoeve 1992, personal communication). Eipo mothers do the same after having started breastfeeding either immediately after the cutting of the cord or approximately 2 hours later (Schiefenhövel 1982).

3.3.2.2 Food for the mother

TBAs on the *Andaman Islands* may give a mother *warm bread* immediately after birth (Kuntner 1988). Mothers in Bangladesh may be given bread ['ruti'] which is 'dry' food. For those who can afford it this bread may be softened in milk and accompanied by banana, or vegetables ['torkari']. In addition mothers are given only *hot liquids* such as tea or milk. There is a strict diet for mothers: the purpose of the diet is to restore the mother's health (Blanchet 1984)(see also 3.3.2.3). In Indonesia Lam (1991) observed (in West Sumatra) [Minangkabau people] a TBA forcing a mother to drink a glass of strong sweet coffee immediately after delivery. Lactating mothers in India (in Andhra Pradesh) consume a concoction consisting of various *herbs* called "MODI" from the fifth to tenth day. Some families give it with *brandy* as it is believed that brandy prevents colds and coughs and keeps the mother and infant warm (Karan et al. 1983).
Remedies for lack of milk have been reported from Indonesia (Batak people): eating the flower of a *banana, raw peanuts or chicken* are advised in order to increase lactation (Priya 1992).
Mothers in Irian Jaya have to avoid several kinds of foods after birth (see 3.3.2.3), but they are advised to eat a lot of *vegetables* (Voorhoeve 1965).

3.3.2.3 Foodtaboos for the lactating woman

Lactating women in many parts of Bangladesh must avoid *'hard', 'cold', 'wet' and 'sour' foods.* It is believed that after giving birth, a woman's flesh is soft and weak inside and therefore 'hard' foods must be avoided. 'Cold' and 'wet' foods are contra-indicated because a woman "needs warmth to ease the pain and her womb must dry out". Women are absolutely forbidden to drink anything cold and *rice* for example is considered too 'wet' and too 'hard'. 'Sour' foods such as *pineapple* must be avoided as it is believed it is not good for the 'raw flesh' inside the woman. "The need for 'hot', 'dry', 'soft' and 'non-sour' foods for the mother is stressed all over Bangladesh, but the foods that fall under each category vary slightly."

"If a new mother does not pay attention to food restrictions, she is believed to be more likely to develop post-partum diarrhoea ['shutika']. Many causes are attributed to this diarrhoea, all of which express the fragility and vulnerability of the mother." (Blanchet 1984)
Voorhoeve (1965) reports from Irian Jaya that a new mother is not allowed to eat *fatty food, meat or fish* during the first weeks up to five or six months after birth. Lactating mothers in India (in Andhra Pradesh) avoid *pulses* in the belief that these promote infection. Moreover they avoid certain *vegetables* (Karan et al. 1983).
The restricted kinds of foods for the lactating women in Asia and the reasons why people believe these foods have to be restricted are presented in Table 3.3.2.3a, Table 3.3.2.3b and Table 3.3.2.3c

Table 3.3.2.3a Taboos on Foods for Growth for the lactating woman in Asia

Kind of Food	Country (Region)	Argument
Eggs	Bangladesh	may cause a prolapse of the uterus
Fish	"	unknown
	Irian Jaya	"
Legumes		
peas	Bangladesh	may cause a haemorrhage
pulses	India (Andhra Pradesh)	may promote sepsis
Meat	Bangladesh	unknown
	Irian Jaya	"
	Indonesia (West Sumatra)	may heat the mothermilk and make the infant ill
Milk	Bangladesh	"

Sources: Amin/Khan 1989; Blanchet 1984; Karan et al. 1983; van Oosterhout 1993; Voorhoeve 1965

Table 3.3.2.3b Taboos on Protective Foods for the lactating woman in Asia

Kind of Food	Country (Region)	Argument
Vegetables	Bangladesh	unknown
	India (Andrha Pradesh)	"
Fruits		
pineapple	Bangladesh	['sour' food is bad for the woman's 'raw' flesh inside]

Sources: Amin/Khan 1989; Blanchet 1984; Karan et al. 1983

Table 3.3.2.3c Taboos on Energy Producing Foods for the Lactating Woman in Asia

Kind of Food	Country	Argument
Staple Foods		
potatoes	Bangladesh	may cause a white secretion
rice	"	[rice = 'wet': rice is bad because the woman needs warmth and the womb must dry out; rice = 'hard': rice is bad for the woman's soft and weak flesh inside]
Fats and Oils		
fatty food	Irian Jaya	unknown
Sugars		
sweets	Bangladesh	"

Sources: Amin/Khan 1989; Blanchet 1984; Voorhoeve 1965

3.4 Latin America

3.4.1 The antenatal period

3.4.1.1 FOODTABOOS FOR THE PREGNANT WOMAN

TBAs in Jamaica may tell pregnant women not to drink *too much water* as this may 'drown' the foetus. They may also advise not to eat *eggs* as it is believed that eggs have the effect of 'cement'; in addition they may advise not to eat *okra* as this makes the baby slide out, since its slippery inner surface is thought to grease the passage (Kitzinger 1978/1982). Mexican women are advised to avoid *milk* in order to prevent a large child who is difficult to deliver (Kay 1982). TBAs in Guatemala [people: Mayan Indians] may prohibit pregnant women eating especially 'cold' foods (as foods are categorized in terms of 'hot' and 'cold'). These foods and the above-mentioned arguments are presented in Table 3.4.1.1a, Table 3.4.1.1b and Table 3.4.1.1c

Table 3.4.1.1a Taboos on Foods for Growth during pregnancy in Latin America

Kind of Food	Country (Region)	Argument
Eggs	Guatemala (San Marcos; Totonicapán)	may harm the child and give him colic
	Jamaica	unknown
Meat		
pork ('carne marrano')	Guatemala	full of fat: child may be born with vernix
Milk	Guatemala (San Marcos; Totonicapán)	is fatty and is like having butter in one's stomach: the child may absorb the fat and slide out [milk = 'cold']
	Mexico	may cause a big child and subsequently a difficult delivery

Sources: Greenberg 1982; Kay 1982; Kitzinger 1978/1982

Table 3.4.1.1b Taboos on protective foods during pregnancy in Latin America

Kind of Food	Country (Region)	Argument
Vegetables		
avocado, beets, cauliflower, potatoes	Guatemala (San Marcos; Totonicapán)	may cause lots of gas and stomach aches occupying too much space which may not not leave enough room for the child ['cold' foods]
beans	"	may give colic [beans = 'cold']
okra	Jamaica	may cause the child to slide out
Fruits		
bitter and sour fruits	Guatemala (San Marcos; Totonicapán)	may stop woman's milk production; may deform a child and abort a foetus ['cold' foods]

Sources: Greenberg 1982; Kitzinger 1978/1982

Table 3.4.1.1c Taboos on energy producing foods and water during pregnancy in Latin America

Kind of food	Country (Region)	Argument
Fats and oils		
fatty foods	Guatemala	may cause the fetus to slip out
Water		
too much water	Jamaica	may 'drown' the foetus

Sources: Greenberg 1982; Kitzinger 1978/1982

3.4.1.2 FOODRECOMMENDATIONS FOR THE PREGNANT WOMAN

In Ecuador (Baquero et al. 1981), Jamaica (Kitzinger 1982) and Mexico (Kay 1982) *tea* is especially recommended during pregnancy: tea laced with brandy, which is thought to bolster her strenght during labour and help speed delivery (Ecuador), bush teas flavoured with bitter herbs which 'cool' the blood (Jamaica) and té de manzanilla ['chamomile' tea] believing that if it is false labour, the pains will go away, and if it is true labour, the pains will come stronger and harder (Mexico). TBAs in Colombia may give 'agua de panela' with 'aguardiente' (= rum) just before the delivery (Durenkamp 1970; Priester 1970). Pregnant women in Colombia and Ecuador are fed *chicken broth* (Baquero et al. 1981; Durenkamp 1970; Priester 1970). TBAs in Jamaica tell pregnant women to eat plenty of 'callalu' [a *vegetable like spinach]* to "enrich the blood". In addition they are told to eat many *fruits,* especially oranges, vegetables (except okra), and *fish* (Kitzinger 1978/1982).

3.4.2 The postnatal period

3.4.2.1 FOOD FOR THE NEWBORN

In many parts of Latin America newborns are *breastfed* (Berggren et al. 1983; Boersma 1985; Jordan 1983; Kitzinger 1978/1982; Nadig 1990 in Kroeber 1990). TBAs in Jamaica may "give a prelacteal feed of *jack-in-the-bush or mint tea,* three drops of *castor oil* are put on its tongue to make it cough up any further mucus and it is then put to the breast" (Kitzinger 1982). As in Haiti the infant's first meconium stools are considered "unhealthy" newborns are given "large doses of castor oil" in order to get the meconium out (Berggren et al. 1983).

Mothers in Haiti are advised to discard the *colostrum* as its yellow colour is looked upon with great suspicion. "TBAs believe that this must be expressed and discarded; such milk will not be considered good for the baby until it is white." (Berggren et al. 1983). Jordan (1983) states that "the TBA gives practical advice about nursing especially to a first mother. Generally, all babies are breastfed. Nursing begins early, sometimes within a few minutes after birth. Whenever the baby shows signs of being hungry or upset it is put to the breast. [Recently, bottle-feeding has increased dramatically, but bottles are still seen as supplemental to breastfeeding rather than as a possible replacement for the breast]." TBAs in Guatemala [people: Maya Indians; Ladinos] may advise to give the newborn tea made from water boiled with anise, sugar, onion stalk, and garlic salt; or tea of 'chicoria' (chicory)(Cosminsky 1982b).

3.4.2.2 FOOD FOR THE MOTHER

TBAs in Jamaica and Mexico make *cornmeal porridge* for the mother after birth. In Mexico this porridge is called 'atole' (Kay 1982; Kitzinger 1978/1982). Jordan (1983) reports from Mexico that a TBA and the assisting women may discuss the mother's first meal and decide to give her *chicken.* Mothers in Haiti may be advised to eat only "white" foods (on the analogy of only "white" milk is good for the infant; see 3.4.2.1), and therefore they may eat just *rice* during the postpartum period. TBAs in Colombia (in Nariño) may give a potion made of marjoram and 'aguardiente' (=rum)(Priester 1970). In Guatemala [people: Maya Indians; Ladinos] *chicken soup, bananas, meat and 'atole' (a corn drink)* are recommended as these foods are believed to strenghten the mother (Cosminsky 1982b). In the regions San Marcos and Totonicapán of Guatemala TBAs may advise women to eat especially *grilled meat,* or *meat soup with caraway** (as these are 'hot' foods which make the woman strong), *toasted 'tamales', 'tortillas' or bread* ("if not toasted, the uterus will hurt") or to drink *beer* (which increases breast milk) (Greenberg 1982).

3.4.2.3 FOODTABOOS FOR THE LACTATING WOMAN

In Colombia (in Nariño) mothers have to adhere to certain foodtaboos during a period of 40 days after birth. This period is called 'dieta'. Unfortunately there is no description of these taboos (Priester 1970).

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* Caraway = plant with spicy seeds that are used for flavouring bread, cakes, etc.

In Guatemala [people: Maya Indians; Ladinos] various food restrictions are followed during the postnatal period. "The most common one is to avoid eating foods classified as "cold" and to eat "hot" foods and drinks. The woman is in a cold state after birth, and in order to restore her bodily balance, she should eat "hot" substances and keep herself physically warm. It is believed that too many "cold" foods will make the mother's milk cold and cause the child to become ill." Some mothers and TBAs indicate that the dietary restrictions are important only if the infant has colic or is sick (Cosminsky 1982b). Greenberg (1982) reports from Guatemala (in the regions San Marcos and Totonicapán) that the following foods are restricted for lactating women: *beans* ('cold' food makes the uterus hurt), *cabbage* (may give colic and stomach ache to the child and may change the taste of the milk), *avocado, milk, garlic, onion, lime, salt, chile, coconut* (coconut may cause breastmilk to become dirty and smelly) and *acidic fruits* (which may stop milk flow and cause children to vomit).

3.5 Discussion

While investigating dietary advices as part of birthing practices of TBAs in Africa, Asia and Latin America we have found information mainly from Africa, less from Asia and only a few reports from Latin America. Therefore there is no balance in the information of the continents. Nevertheless we have tried to compare the information in order to find out which traditional food habits are common and which are different to all three continents.

A common reason for restricting foods during pregnancy in all three continents appears to be *the fear that a child may grow too big* because of the expected complication of a delayed or obstructed labour. In order to restrict the growth of the child there are taboos on certain foods during pregnancy, which – according to the Nutritional Classification 'Basic Food Plan' – include Foods for Growth and Energy Producing Foods:

- in Africa: eggs, meat, milk/staple-foods, fats and oils, sugars,
- in Asia: fish/fats and oils, sugars,
- in Latin America: eggs, milk.

Another common reason for restricting food during pregnancy in all three continents appears to be *the fear of a miscarriage.* Trying to prevent this there are taboos especially on Protective Foods:

- in Africa: (bitter and sour) vegetables, (bitter and sour) fruits,
- in Asia: fruits (pine-apple; durian),
- in Latin America: vegetables (especially okra), (bitter and sour) fruits.

Fear of skin problems appears to be another reason for restricting especially Protective Foods, just reported from Africa and Asia. In order to prevent skinproblems there are taboos on vegetables and fruits:

- in Africa: eggplant; bananas; lemon or monkey bread,
- in Asia: eggplant.

To prevent *the birth of twins* there is a taboo on eating twin bananas during pregnancy in Africa and Asia.

In all three continents newborns are breastfed, but the *colostrum* is generally discarded and generally water with sugar is given instead. In addition a very first food may be given immediately after birth before lactation has been fully established, which has appeared to be highly symbolic.
Foodrecommendations for the mother in the three continents include especially Foods for Growth and Energy Producing Foods (milk, meat, chicken, porridge, bread, tortillas, rice).
It seems there are not many foodtaboos for *lactating* women in Africa. Mothers in Asia have to avoid 'hard', 'cold', 'wet' and 'sour' foods, while mothers in Latin America should especially avoid 'cold' foods. These foods include mainly Foods for Growth (such as fish, eggs, grain legumes and milk) and Energy Producing Foods (such as rice and potatoes). But in Latin America these foods also include Protective Foods ('cold' foods such as beans, cabbage, avocado, fruits).

4 Training of Traditional Birth Attendants

4.1 Introduction

As mentioned earlier TBAs deliver at least two thirds of all babies in Africa, Asia and Latin America (see 1.1). As a reaction to the view that TBAs are "native death-angels" (see 1.3) it has been tried – since the beginning of this century – to upgrade the performance of TBAs. Originally this was done by individual physicians or nurses on their own initiative, but from the early fifties official training-programmes were organised in many countries. When it was realised that it was hard and expensive to train enough *professional midwives* a more systematic approach to the training of TBAs was started by the WHO in *1972*. In those days the main goal of training TBAs was to improve the perinatal services in Africa, Asia and Latin America where one baby out of 12 dies during the first year of life and one mother out of 100 dies during pregnancy and delivery. Many TBAs have been trained in the three continents since 1972.
A recent WHO Statement – published in *1992* – reveals that training of TBAs is still widely promoted for the future. It has been indicated that "because of the current shortage of professional midwives and institutional facilities to provide prenatal care and clean, safe deliveries as well as a variety of primary health care functions" training of TBAs has to be encouraged "in order to bridge the gap until all women and children have access to acceptable, professional, modern health care services". At present the main goal of training TBAs still is to reduce maternal and child mortality and morbidity, and, in addition to improve reproductive health. In order to achieve this TBAs have to augment their tasks. Trained TBAs may as well as "doing what may be termed risk assessment in the prenatal period and referring mothers to the health centre" also be expected to take on "expanded primary health care functions in a variety of fields including family planning, first aid, health education about nutrition, breast-feeding, personal and environmental hygiene, prevention of transmission of the human immunodeficiency virus (HIV), and promoting the importance of bringing infants to the clinic for growth monitoring, immunization, and treatment of infections" (WHO 1992). This is the policy for the near future, but what has been realised until now? In this Chapter a description of the learning objectives and course content of trainingprogrammes of TBAs before and after 1972 is given.

4.2 Trainingprogrammes for TBAs before 1972

Already since the beginning of this century individual physicians, midwives and/or nurses (for example in Indonesia, or the Sudan) have trained TBAs (Bella 1980; El Hakim 1981; van Gulik 1930; Hydrick 1927/1936; Verdoorn 1941; Voorhoeve 1965). From the early fifties onwards – during the earlier years of WHO's existence – several countries have started trainingprogrammes for TBAs. In Thailand for example the Government started a trainingprogramme for TBAs in 1952 in order to reduce maternal and infant mortality. The purpose of the training was to teach the TBAs about antenatal care, the techniques of delivery, and postnatal care. Under this programme nearly 17 000 TBAs received a training of 2 weeks duration by the end of 1968. In 1970 the Government decided to focus their attention more on family planning.
In general it is not easy to point out when exactly WHO's activities concerning the training of TBAs started. In some of WHO's Member States the "training has been going on rather sporadically for many years and quite often as a rather muted part of WHO-assisted projects for the development of MCH services or of basic health services generally. This low-key approach reflected, if not categoric opposition in the WHO to the training of TBAs, at least wishful thinking on the part of some authorities that, within the near future, there would be no need to rely on TBAs for midwifery services and that, therefore, the interim period could be quietly ignored" (WHO 1979c). A summary of some of the first trainingprogrammes for TBAs in Asia initiated since 1950 is given in Table 4.2

Table 4.2 Summary of some training programmes for TBAs in Asia initiated since 1950

Country	Year	Training programmes
India	?	Various states (Punjab, Madya Pradesh) have reported registration and training programmes for TBAs
Indonesia	>1965	An estimated 29,000 TBAs were trained under the auspices of UNICEF and local government MCH services
Malaysia	1962-63	Midwifery training given to a small number of TBAs
W. Pakistan	?	On-the-job training provided for TBAs in rural areas. Training given by Public Health Schools in urban areas, district hospitals and MCH centers
Philippines	1954-72	8,866 TBAs trained in programme sponsored by government and WHO/UNICEF. Upon completion of course, trainees were given a midwifery kit
Thailand	>1967	UNICEF sponsored training of an estimated number of 18,000 TBAs over 17-18 year span

Source: Neumann et al. 1974

In these early programmes training in hygiene played an important part as it was assumed that a considerable proportion of infant deaths could be averted by clean hands and the use of sterile instruments. In the Philippines a TBA training programme was initiated in 1954 by the Department of Health with the assistance of WHO and UNICEF. This programme consisted of a 12 week course of 3 hours per day. The objectives of the training were:

1 "making the practices of TBAs less dangerous by teaching them
   a the importance of clean hands
   b the use of clean equipment
   c not to intervene
   d when to call for the help of the physician or nurse/midwife
2 bringing TBAs gradually under the supervision of trained persons."

After completion of the course TBAs received a UNICEF midwifery kit* (Mangay-Angara 1974).

In Irian Jaya (former Western New Guinea) a trainingprogramme for TBAs was initiated in 1959. The trainingsession lasted 2 weeks. Five topics were covered:

a hygienic methods: teaching to assist at birth with clean hands and clean instruments and wearing clean clothes
b the importance of nutrition for mother and child
c the baby's position in the womb
d the actual delivery i.e. the three stages of the intrapartum period: dilatation, expulsion of the child and the birth of the placenta
e first aid in emergency and difficult cases, e.g. retained placenta or postpartum haemorrhage

All teaching was done in a more practical way: washing hands thoroughly and playing with a set of cards on which 'foods for growth', 'protective foods' and 'energy producing foods' were classified. After completion of the course the TBAs received a UNICEF midwifery kit (Biersteker 1961; Voorhoeve 1965).

4.3 Trainingprogrammes for TBA's since 1972

Considering WHO's more systematic approach with reference to TBAs, the year 1972 may be identified as the starting point, since it was "in that year that the WHO (...) launched a worldwide survey aimed at identifying the characteristics of TBAs, the extent of their involvement in maternal and child health and family planning programmes, their beliefs and practices, their legal status, the characteristics of training programmes for TBAs, methods of supervision, etc.". In 1978 an International Conference on Primary Health Care (PHC) was organised in Alma Ata (former USSR). During this Conference it was recommended to explore the possibilities of engaging TBAs in PHC and to train them accordingly (WHO

* UNICEF midwifery kit = a box made of aluminium filled with items such as a sponge bowl, gauze pads, soap, plastic sheets, an apron, scissors etc., provided by UNICEF.

1978). Since then trainingprogrammes of TBAs exist in many countries. Pillsbury (1982) reported that TBAs have been given formal training in at least 44 countries. The length of these programmes varied from a few days to a couple of weeks; at the end of a training course TBAs usually received a certificate and a UNICEF midwifery kit.
In a field guide about the training of TBAs published by the WHO (1979b) it was discussed "how the TBA's current practices could be improved, what additional tasks they might be able to perform, and how the services of TBAs could be "articulated"* with those of the organized or formal health services". Thus TBAs should have to work with the organized health system in such a way that the traditional and the organized health systems could fit into each other. The term "articulation" is preferred to the term "integration" because the latter may indicate a more close connection of TBAs into the organized health system, which could mean that they "finally lose their identity as perceived in the traditional sense. This might well lead to a conflict between TBAs and other categories of health personnel working in the organized services, as well as between TBAs and the communities they are expected to serve." In addition the concern was expressed that "within the TBA as a person, modern and traditional concepts and modes of practice are so integrated as to eliminate only traditional practices and rituals that are clearly shown to be harmful, and to instil only modern concepts and techniques that are absolutely essential to the safety of the persons under the care of the TBA" (WHO 1979b). And this concern should be taken into account in planning the learning objectives and course content for each trainingprogramme.
In order to give an insight into the policy concerning TBAs carried out in different areas since 1972 a description is given of the learning objectives, course content, and the reported evaluation of the performance of the trained TBAs. Reports of trainingprogrammes were selected which presented explicitly these aspects of the training for three countries of each of the continents Africa, Asia and Latin America. In addition to the paragraph 'In Africa' (see 4.3.1) a description will be given of all the trainingprogrammes for TBAs in Ghana as our fieldstudy took place in that country (Chapter 5).

4.3.1 In Africa

Review of the literature revealed that TBAs were given formal training and were utilized as service providers in Cameroon, Central African Republic, Chad, Ethiopia, Gambia, Ghana, Kenya, Liberia, Mali, Niger, Nigeria, Senegal, Sierra Leone, Somalia, Sudan, Tanzania, Burkina Fasso, Zambia and Zimbabwe (Chalmers 1990; Daly/Pollard 1990; Kamal 1992; Pillsbury 1982).

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* The verb "articulate" was defined according to Webster's Dictionary of Synonyms' definition of "articulation" which "implies organization in which each part fits into another in a manner comparable to the fitting into each other of two bones at a movable joint and a structure so built that it functions as a whole yet without loss of flexibility or distinctness in any of its component units or without any conflict between them".

The Ministry of Health of *Sierra Leone* started a TBA training programme in1974. Two 3-week courses have been held twice a year attended by approximately 30 TBAs in each course. Thus about 120 TBAs have received training annually since 1974 (West 1981a). It has been reported that the work which the trained TBAs were expected to master included midwifery, child care, hygiene, home visiting, health and nutrition education, and family planning. During the first 2 weeks of a training session only classroom teaching was given while the third week was almost entirely practical. The major topics dealt with were maternal care, child care, and community health (see Table 4.3.1a and Appendix 1a for details).

Table 4.3.1a Course content of a 3-week training session for TBAs in Sierra Leone

First week: maternal care Home visiting; antenatal clinic; examination during antenatal period; nutrition during pregnancy; preparation of mother for labour and delivery; demonstration of delivery; care of the newborn; care in the puerperium etc.
Second week: child care and community health The under-5 clinic; immunization; use of the weight chart; (breast)feeding and nutrition; community health; environmental sanitation etc.
Third week: practicals and family planning Health centre practice and observation; family planning; child spacing and need for this; etc.

Source: West 1981a

Evaluation of the performance of the TBAs after training has been carried out by one hospital only. Comparison of the performance of TBAs before and after training indicated, that not all the results of training were positive. "Villagers with raised expectations of the trained TBA's new skills looked down upon the TBA when they discovered limitations in her new methods. As for the TBA herself, with no firmly founded belief that her newly learned practices do indeed work, with her integrity challenged, with loss of her position [in the community] threatened, and with no visible support from authorities, she may (...)revert to some of her old practices. Similarly, when the UNICEF kit is depleted the TBA may resort to her old 'medicines' and implements, especially when visits to the hospital are fruitless because the hospital itself is short of supplies." (West 1981a)

In *Liberia* the Ministry of Health and Social Welfare formulated a curriculum for a TBA trainingprogramme to be used in different counties of the country (see Table 4.3.1b and Appendix 1b for details). [The exact duration of the course was not indicated; YL]

Table 4.3.1b Course content of a training programme for TBAs in Liberia

Antenatal care Identifying anaemia; estimating gestation; recognizing high-risk mothers; conducting home visits etc.
Care during intrapartum period Preparing mother, equipment, and place of delivery; observing contractions; managing and inspecting the placenta etc.
Care during postnatal period Giving proper cord care; identifying abnormalities in the newborn; teaching mothers proper breastfeeding techniques; making appropriate referrals etc.
Family planning Teaching child spacing; identifying families with problems of infertility etc.

Source: Lartson et al. 1987

Lartson et al. (1987) indicated that TBA training should serve a twofold purpose:

1 teaching TBAs:
   a the principles of clean delivery,
   b the anticipation and diagnosis of obstetric complications for which they need to refer the mother to a clinic or hospital,
   c basic preventive measures in the care of obstetric patients (e.g. keeping the bladder empty, proper pushing techniques, etc.),
   d basic emergency measures,
   e principles of child spacing,
   f nutrition, child care, and prevention of communicable diseases,
2 to give recognition and credibility to the TBAs' ability in order that the community will use their skills and knowledge to their best advantage.

Evaluation showed that when the performance of trained TBAs was compared to untrained TBAs the former "performed better with regard to history-taking, dietary advice, assessment of pregnancy, knowledge of risk factors, and handling of the cord compared to the untrained TBAs". But it was finally concluded that practices and routines which are deeply rooted in the local culture cannot be changed by a few weeks of lectures and demonstrations. Despite the training (and a system of supervisors) TBAs were still handling referable conditions such as breech, twin deliveries, retained placenta and prolapse of the cord even though referral to a health centre was possible.

In 1983 a Primary Health Care programme was introduced into the Farafenni area of *The Gambia*. Training of TBAs was an important part of this programme. Sixteen villages in the area joined the programme. Each village selected a TBA. The selected TBAs received a ten week training course. The main purpose of training them was to improve their skills in order to reduce maternal morbidity and mortality and the neonatal death rate. A detailed course content was not described, but it was reported that TBAs were taught to advise pregnant women on ante- and post-natal care, including possible referral to a health centre or hospital for delivery. Each trained TBA was supplied with a midwifery kit.

During a 5-year period (1982-87) a study was carried out in which villages with and without a training programme were compared.
Evaluation of the effect of TBA training and the impact of trained TBAs on the outcome of pregnancy revealed that training of TBAs may have played some part in improving the outcome of pregnancy and in bringing about a reduction in maternal and neonatal mortality, although other factors, such as the upgrading of the health centre or improvements in the transport system, could not be excluded. In addition it was stated that "more women attended antenatal clinics, received tetanus toxoid immunization and delivered in a health centre than before the introduction of the PHC programme". Unfortunately a direct effect of TBA training on the perinatal practices of TBAs could not be demonstrated. There were only speculations such as "the TBAs might have had an effect on maternal mortality by encouraging women to attend the antenatal clinic and by referring those with a complication of delivery" or "the PHC programme might have improved obstetric care not only in PHC villages with their trained TBAs but also in non-PHC villages through contacts between trained TBAs and untrained birth attendants in neighbouring villages" (Greenwood et al. 1990).

The year 1971 may be identified as the starting point of a systematic approach in connection with TBA training in *Ghana.* In this year an eight-year training, research, and demonstration project was set up in Danfa, a rural zone of the Greater Accra Region. It was called: *the Danfa Comprehensive Rural Health and Family Planning Project**. Training and integration of TBAs within a comprehensive maternal health programme was planned aiming at reducing maternal and infant mortality. There were four study areas, located in a rural district centered about 29 km north of Accra. The areas contained 310 villages and 60,000 people, most of whom were living in villages with 100-400 inhabitants. Three study-areas received family planning services and in 1972 263 TBAs were registered: with the cooperation of the chiefs and schoolteachers from each TBA basic information was collected on age, sex, years in practice, and estimated number of deliveries in the past year.
In 1973 a questionnaire was administered to a subsample of the TBAs registered. The sample included all TBAs in one of the three study areas where a training-programme was conducted, and a subsample (17%) of the TBAs in the other two areas. Interviews were carried out in the local language by public health nurses who were familiar with the areas. 82 of the 263 TBAs previously registered in the Danfa project were interviewed; 34% of those interviewed were men. In addition 60% of the TBAs in one of the three areas were asked to demonstrate their practices.
Evaluation after a few years of experience this project revealed that trained TBAs attended more deliveries, performed prenatal care, treated the umbilical cord in a sterile way, and, according to them, referred women for Family Planning (Ofosu-Amaah/Neumann 1979).

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* The Danfa pilot project was undertaken jointly by the University of Ghana Medical School at Korle Bu and the School of Public Health of the University of California at Los Angeles, and funded by United States Agency for International Development (USAID).

Apart from the Danfa Project another pilot project was set up in the region Brong Ahafo (see map pg 104): the *Brong Ahafo Rural Integrated Development Project (BARIDEP).* In the town Techiman, for example, TBAs received training as part of this project during 1977-78 by the staff midwife of the Holy Family Hospital. A series of classes were given in a nearby village while practical experience was provided at the hospital. The course content "covered basic anatomy and physiology, antenatal care including early detection of abnormalities, diet and nutrition during pregnancy and lactation, mechanisms of labour and delivery, intrapartum care, with emphasis on hygiene and safe practices, postpartum care and care of the newborn, with emphasis on sanitary treatment of the cord". At the end of the course the TBAs were presented to the public with due ceremony and they received a UNICEF midwifery kit.
Evaluation revealed in particular an improved relationship and increased mutual respect between hospital midwives and the TBAs (Warren/Tregoning 1979).

From the experience gained from the Danfa and BARIDEP projects the Ministry of Health (MOH) in Ghana decided to introduce in 1979 the Ghana Primary Health Care Strategy in one district per region. Training of TBAs formed an essential part of this strategy (see also 5.1.2.1). Lessons learned from the projects "emphasized the importance of providing clear guidelines for the TBAs for the performance of their duties as their skills were upgraded and expanded". In addition it turned out to be important that "TBA trainers were qualified midwives or other professionals with knowledge of and respect for local language and customs". Visual aids and TBA training manuals were used in training courses. Continuous support and supervision of the trained TBAs and promotion of community involvement were planned, but not performed so far. Unfortunately when trainingprogrammes were started they were hard hit by the severe decline in the Ghanaian economy which characterised the late 1970s and early 1980s (see also 5.1.1).

In the mid-1980s when the economy improved the MOH was determined to continue the previous positive experiences with TBAs and started a *National TBA Programme**. In 1987 a new pilot project was inaugurated in the Dangbe District of the Greater Accra Region**. The goal of this project was "to operationalise the delivery of improved midwifery, FP and other PHC interventions by establishing effective training and supervision links between TBAs, health post and district staff". The first region of Ghana to implement its TBA training activities under the national programme was Volta Region (which is divided into 5 districts, with a total population of 1.2 million). In the Dangbe District and in the Volta Region

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* Technical assistance and funding of the National TBA Programme was provided by the American College of Nurse-Midwives with a grant from USAID/Accra for work in 5 regions and by UNICEF, United Nations Fund for Population Activities (UNFPA) and the World Bank for the other 5 regions.

** Financial and technical assistance in relation to this project was given by the Center for Population and Family Health of Columbia University in the USA.

programme activities were undertaken to "prepare the health post staff, the communities and the TBAs for their respective responsibilities. These activities included: Training of Trainers (TOT), workshops for health post staff, selection of TBAs for training, TBA-training, supervision and monitoring after training." TBA-training consisted of a 6 to12 weeks course, with trainingsessions once or twice a week. Most sessions required about four hours per day. The MOH formulated a curriculum for TBA training in Ghana described in the 'Manual for the Training of Traditional Birth Attendants in Ghana' (see Table 4.3.1c).

Table 4.3.1c Course content of a 6 to 12 weeks training programme for TBAs in Ghana

Session	Topic
1	Getting acquainted
2	Caring for pregnant women
3	Problems in pregnancy
4a	Germs and the need to be clean
4b	Preparation for birth
5	First stage of labour
6a	Second stage of labour
6b	Third stage of labour and care of mother and newborn
7a	Care of the newborn baby and mother in the days after Delivery
7b	Breastfeeding
8a	Weaning
8b	Growth monitoring
9	Family planning
10a	Immunisation
10b	Diarrhoea and oral rehydration therapy
11a	Making referrals
11b	Record keeping
11c	Home visits

Source: Ministry of Health Ghana; Final Report Operations Research Project 1990

After training the TBAs would get an identification card, a certificate, and a kit*. It was decided that the replenishment of the kit would be the responsiblity of the TBAs themselves. In addition it was decided that it was up to the TBAs to decide how much to charge for their services: the programme did not set prices for specific services.
As the pilot project in Dangbe District was a model for the National TBA Programme it was "necessary to study and document its planning, implementation, follow-up and the effects of the effort. Therefore a number of qualitative and

* The kit consisted of a wooden box with the following items: 2 bowls, plastic apron, nail brush, soap dish, toilet soap, packet of blades, hand towel, cord ligatures, plastic bag of cotton wool, contraceptives (condoms and foaming tablets), sachets of ORS, record books, referral cards.

quantitative operational research studies were also carried out in this project. These studies were designed to provide useful data for the programmatic aspects of the TBA project. The information was collected to give regular feedback to project managers, and at the end of the project as part of a final evaluation." Twenty researchers of the University of Ghana in Accra worked in teams of two during one month of data collection. One district in each of the 10 regions of Ghana* was selected as the study areas for the National TBA Programme.

Source: Morrow 1983

* Ghana is administratively divided into regions which are subdivided into districts.

The selected districts were:

Region	*District*
Western Region	Ahanta District
Central Region	Mfansiman District
Accra Region	Dangbe District
Eastern Region	Suhum District
Volta Region	Ho District
Ashanti Region	Asante-Akim District
Brong-Ahafo Region	Techiman District
Northern Region	Tamale District
Upper West Region	Lawra District
Upper East Region	Bawku District

Danfa in the Accra Region was included as an eleventh study area as it was the centre of the most extensive TBA training programme in Ghana. In each of the districts the researchers interviewed "TBA programme managers and trainers, community opinion leaders, community women and TBAs themselves." General findings regarding the TBAs' characteristics (see 5.1.3) and the communities' reactions tended to besimilar in the studies. As far as the reactions from the 'community' are concerned, community opinion leaders and women were very positive about the work of TBAs. Most of the women described their experience with the TBAs as very pleasant. Asking for an explanation why people preferred the TBAs to health centres for deliveries a few reasons were given by both the opinion leaders and women: "The costs were far lower with the TBAs especially when transport was considered, it was preferred to deliver in one's own environment, people had confidence in the TBAs due to their age and experience and considered them as family friends and the TBAs were always available and responsive to any call."

Many of the TBA training programmes, although carried out independently, faced similar problems.

Evaluation of these problems showed that:

a a separation of training and supervision responsibilities resulted in an insufficient continuity in the TBAs' overall learning process because the trainers were not the supervisors of the TBAs and the supervisors were largely excluded from training responsibilities,

b transport difficulties were due to poor roads and insufficient vehicles for the programme,

c the community did not participate into the programme as had been anticipated; for example it was expected that the community would replenish the TBAs' kits and provide adequate remuneration but this did not happen,

d "the community, the TBAs themselves and the trainers had high expectations of the training. The community expected better services seeing the TBAs as part of the health system which had to cater for their needs." The trained TBAs wanted to be paid in order to be able to replenish their kit and the trainers expected the TBAs to practice all the new skills including those which required the use of the items of the kit,

e there was difficulty in changing long-held and deep-seated beliefs and practices of the TBAs which were considered to be harmful. For example, the practice of withholding protein-rich foods from pregnant women (MOH Ghana 1990).

In the pilot area of Dangbe District 74 of the original 118 *trained* TBAs were interviewed in order to gather data on their basic characteristics, practices (see 5.1.3) and performance. [The remaining TBAs were not interviewed because they were not at home on the day of the survey].
Evaluation of TBA performance since training revealed that "they retained and practiced much of what they had been taught in the areas of antenatal care and delivery." The majority of the TBAs (83.6%) offered antenatal activity even though more than one year had passed since training; the TBAs asked "relevant questions for screening and examined their antenatal clients effectively". 70.7% of the TBAs indicated that they referred women with complaints in early pregnancy (such as general weakness, pain in the lower abdomen, spotting, headaches and heartburn) to the health post, while 55.7% referred women with complaints in late pregnancy (such as backaches, lower abdominal pains, general fatigue and swollen feet). But the TBAs were not active in Family Planning and reluctant in other PHC interventions which they had been taught (activities regarding breastfeeding, weaning and diarrhoeal disease control).

In *the Volta Region* a TBA Panel Study was initiated to assess the activities of *trained* TBAs. Three rounds of in-depth interviews were conducted by 11 TBA-trainers, randomly selected from the health posts in the region. Round 1 was scheduled just before the training, Round 2 immediately after and Round 3 three months later. A two-step sampling procedure was used:
1) ten of the twenty health institutions which had participated in the Volta Region Training of Trainers workshop were randomly selected, 2) five TBAs from each of these institutions were randomly chosen to participate in the study, for a desired sample size of 50. The same TBAs were interviewed for each Round. Round 1 interviewed 48 of the 50 TBAs selected. However not all TBAs had completed training by the time Round 2 interviews were conducted, and Round 3 interviews were impossible in many cases because insufficient time [4 to 6 weeks and not the desired three months] had passed since training. The study could not be extended as the end of the operations research project was reached. The final sample sizes were 48 for Round 1 and 35 for Round 2.
Evaluation of TBA performance after training revealed that the antenatal activity of the TBAs had increased. Before training only 23.9% of the TBAs had ever given antenatal care while immediately after training 80% was doing it. "They gave nutritional advice, asked the appropriate screening questions and performed the correct examinations for pregnant women."
All of the TBAs indicated that they "washed their hands and cleaned the mothers' genitals for the delivery". Before training they "relied on their own methods of determining the stages of labour, but [after training] on the established signs of labour onset". In addition after training the TBAs used "cord powder or spirit" instead of the traditional herbs when dressing the umbilical cord. Before training "few had given the mother any advice on weaning or breastfeeding. Afterwards the

great majority did so, recommending solid foods at about 4 months and breast-feeding for more than 1,5 years." Finally the evaluation revealed that after training the TBAs appeared to prefer the lying position instead of the traditional squatting position; this was considered to be an "unfortunate finding" as the traditional practice of the squatting position during delivery which was known to be beneficial should have been continued and *not* have been changed.

From the experiences gained from the projects in the Dangbe District and Volta Region, the National TBA Programme started in April 1989. The goal of the programme was "to increase access to improved PHC and FP services by involving TBAs in the provision of these services". Training of Trainers workshops were held from August to September 1989 and the training of TBAs was conducted from October 1989 till June 1990 (MOH Ghana Final Report 1990).

4.3.2 In Asia

Review of the literature revealed that TBAs received (formal) training in Afghanistan, Bangladesh, India, Indonesia, Malaysia, Nepal, Pakistan, the Philippines, and Thailand (Pillsbury 1982).

In *Thailand* training or upgrading of TBAs has been conducted since 1952 (see 4.2). Since 1970 this trainingprogramme has been an important component of the national family planning programme. From 1977 the training has been devoted not only to family planning but also to MCH and PHC. The training course for TBAs lasted 35 hours, confined to one or two 2 weeks. Since the TBAs already had previous experience in delivering babies, and had sometimes been previously trained, the course content focused more intensively on family planning and other primary health care activities (see Table 4.3.2a for details).

Table 4.3.2a Course content of a 35-hour training programme for TBAs in Thailand

Family planning Socioeconomic and public health problems created by having too many children; reproductive organs (male/female) and pregnancy; contraceptive methods; necessity of follow-up, referral, and record keeping; role of TBAs, duties, scope of operation, and availabe resources
Maternal and child health Antenatal, postnatal, and infant care; delivery and symptoms of abnormalities
Health education and techniques to motivate people to accept services
Basic health care First aid; personal hygiene; identification and prevention of common communicable diseases; nutrition
Miscellaneous Record and reporting; opening session and orientation; discussion and closing session

Source: Sujpluem et al 1981

The specific objectives of the course were "to enable the TBA to assist members of the community by:

- explaining the problems ensuing from having many children,
- explaining the various methods of contraception currently being promoted by the National Family Planning Programme,
- distributing oral contraceptives to women who have already received an initial supply distributing condoms and explaining how to use them correctly,
- advising pregnant women and mothers of newborn babies how to take care of the newborn,
- assisting mothers in the delivery of babies at home, using proper and aseptic techniques,
- explaining the importance and methods of personal hygiene,
- providing basic first aid,
- identifying the symptoms of various communicable diseases, and reporting them to the health centre, and assisting in the control of such diseases,
- advising on ways to improve environmental sanitation,
- explaining the various sources from which health care can be sought,
- referring patients in need of care beyond that which she is capable of providing".

The TBAs who successfully completed the course received a certificate, a delivery kit, a flipchart, and a manual similar to the ones used during the training period. In 1978 a study of the performance of TBAs was carried out by comparing a group of 86 TBAs (in Udornthani Province) who had been trained in MCH and Family Planning and a group of 122 untrained TBAs (in Sakon Nakhon Province)(Sujpluem 1979). A questionnaire was administered to the TBAs by specially trained interviewers. There were 20 questions in the questionnaire concerning practices,15 concerning attitudes, and 40 concerning knowledge. A summary of the responses given by the TBAs concerning their *practices* is given in Table 4.3.2b

In addition two summaries of responses given by both groups of TBAs [i.e. 86 trained TBAs and a control group of 122 untrained TBAs] concerning their *attitudes* to various aspects of maternal and child care, and their *knowledge* regarding maternal and child care were presented.

Evaluation on the basis of all responses of the *trained* TBAs concerning their practices, attitudes and knowledge in connection with maternal and child care revealed "a number of areas in which the training did not succeed to the extent envisaged. These included:

- *practices* concerning the cleansing of the instrument to be used for cutting the umbilical cord, the delivery of the placenta, the management of postpartum bleeding, and the management of the client's side-effects from the use of certain contraceptive methods,
- *attitudes* concerning the necessity of postpartum check-ups at the health station, and the perception of family planning as not corresponding to the interest of the TBA,

Table 4.3.2b Summary of responses given by 86 trained TBAs and a control group of 122 untrained TBAs in Thailand concerning their practices,1978

Practices	Percentage of correct responses given by:	
	Trained TBAs (n=86)	Control group (n=122)
Advice about prenatal check-ups at health stations	97.7	86.1
Advice about blood test for detection of sexually transmitted diseases	94.2	78.7
Practice of handwashing	74.4	8.2
Practice of inserting finger into birth canal of mother	83.7	63.9
Practice of pushing on woman's abdomen during labour	81.4	8.2
Instrument used for cutting umbilical cord	93.0	29.5
Pre-cleansing of cutting instrument	52.3	11.5
Delivery of placenta	58.1	48.4
Management in case of abnormal labour	79.1	66.4
Management of baby's cord after cutting	79.1	24.6
Application of eye-drops to baby's eyes	96.5	25.4
Advice about check-ups for infant at health station	89.5	67.2
Advice about immunization of infant	88.4	90.2
Advice about birth registration	96.5	89.3
Management of postpartum bleeding in mother	34.9	15.6
Advice about postpartum check-ups at health station	98.8	77.0
Advice about availability of family planning services	97.7	77.0
Advice about family planning practices	98.8	85.2
Referral of clients for family planning services	79.1	36.9
Management of client's side-effects from use of contraceptives	63.9	67.2

Source: Sujpluem et al. 1979/1981

– *knowledge* about certain symptoms and discomforts of pregnancy, treatment of the baby's infected or bleeding cord, the proper weaning period, the appropriate time for couples to resume sexual activity after the birth of the baby, the availability of contraceptives in injection form, the location of the IUD in the body, and the health service units offering vasectomy and tubal ligation operations".

In addition it has been stated that "most of the *untrained* TBAs appeared to possess a considerable amount of knowledge about MCH and familyplanning, that many of them appeared to have a positive attitude to scientific practices and concepts in this area, and that a notable number of them appeared to be willing to provide advice about family planning and to serve as distributors of contraceptives. To what extent the above may be due to the possibility that many or most

of the so-called 'untrained' TBAs in the sample had received training from earlier programmes is not known." In addition evaluation revealed among other things that "variables such as age and educational level did not appear to influence the TBA's learning capacity, but a more important factor – perhaps related to age in certain cases – was the poor vision of many TBAs, most of whom did not wear glasses, probably because they could not afford them." (Sujpluem et al. 1981)

The Government's training programme for TBAs in the *Philippines,* which was already started in 1954 (see Table 4.2), has been intensified in 1975. This programme covered "only the traditional services provided by TBAs, i.e. care of the mother during pregnancy, especially during the second and third trimesters, delivery, care of the newborn, and care during the postnatal period." In addition, family planning has been incorporated into the programme. The training course consisted of 10 sessions each lasting 4 hours or more. These sessions were usually spread over a 10-day period, with one session per day. "When necessary, the duration of the course could be shortened to 8 days by combining certain sessions. Generally, the sessions were conducted on consecutive days. When the needs of the TBAs demanded otherwise, however, the course was spread over several weeks, with one or more sessions per week." The methods used were lectures, group discussion, demonstration, role-playing and group work. The content of the course is described in Table 4.3.2c (see Appendix 1c for details).

Table 4.3.2c Course content of a 10 day (= 10 sessions) training programme for TBAs in the Philippines

Session 1	*Orientation*	Discussion on the purpose of the training etc.
Session 2	*Infections*	Discussion on the concept of harmful organisms etc.
Session 3	*Delivery kit*	Explanation and demonstration of the use of each item in the kit etc.
Session 4	*Care during pregnancy*	Discussion on the concept of prenatal care and its importance etc.
Session 5	*Care during labour*	Discussion on the TBA's traditional beliefs and practices with respect to pregnancy, labour and delivery etc.
Session 6	*Care of the newborn*	Instruction on how to stimulate respiration, to cut and dress the cord etc.
Session 7	*Postnatal care*	Discussion on the normal puerperium, the signs and symptoms that indicate the need for referral etc.
Session 8	*Birth registration*	Instruction on how to record data on births in a notebook etc.
Session 9	*Family Planning*	Discussion on the implications of frequent pregnancies and large families etc.
Session 10	*Summary; follow-up*	TBAs are encouraged to express their opinion of the course etc.

Source: Mangay-Angara 1981

The UNICEF midwifery kit which the TBAs received after finishing the course appeared to be very important: with the kit the TBAs could show the community that they had undergone training.
In 1978 there were about 19 550 trained TBAs practising in the Philippines, including the 8.866 TBAs who were reported as having been trained in 1972 (see Table 4.2).
Evaluation of the performance of the trained TBAs has not been realised as it has been indicated that considerable improvement would be needed in the system of information gathering and analysis. "There is practically no solid evidence to show either the quantity or quality of the health work performed by trained TBAs. The lack of evidence is due not only to underreporting of vital events but also to deficiencies in the content of many of the birth and death reports that are made. Aside from this, resources for the supervision of the TBAs are not sufficient to permit systematic, direct observation of their performance."(...) "Some attempts have been made to train TBAs for health work in relation to birth attendance (e.g., in primary health care and nutrition). There is little information available to show the degree of effectiveness of such training. Until more evidence in this respect is available, it is not possible to pass valid judgement on whether efforts should be pursued to enlarge the TBA's range of tasks." (Mangay-Angara 1981)

At Pachod (Maharashtra State) in *India* the Comprehensive Health and Development Project was started in 1977. 22 Villages were covered by the project. Training of TBAs in all the villages formed an important part of the project. From the beginning it was realised that in order to bridge the cultural gap between trainers and TBAs (with their clients) a very sensitive problem-solving approach to the training had to be adopted. "Most TBAs had been assisting deliveries by traditional means for 25 to 30 years. It involved changing a deeply entrenched set of values, beliefs, and practices. Simply telling the TBAs outright that their practices were harmful would have created serious psychological barriers and resistance to the acceptance of new knowledge and practices." Firstly a detailed inventory of the TBA's attitudes, knowledge and practices was carried out, and then a trainingprogramme designed. This programme aimed at changing harmful practices, encouraging beneficial traditional customs, reshaping attitudes and values, and adding new knowledge. It was realised that *changing harmful practices* required a very sensitive approach. For example, one practice considered to be harmful was "giving newborns two spoonfuls of castor oil in the belief that a catharsis was necessary to remove the fluids of the womb ingested by the newborn during birth". As it was understood that this often caused severe diarrhoea which may lead to dehydration and death it was attempted to modify this practice. TBAs were asked whether there were any alternative laxatives sufficiently mild for a newborn baby. The TBAs suggested various traditional herbal laxatives. One suggested honey, which was available in all villages. Through consensus it was decided to recommend a spoon of honey as a laxative for the newborn. This became a practice now widespread in the project area. A practice which was considered to be harmful was discouraged while avoiding the creation of psychological barriers to change. *Health and nutrition education* formed another part of the trainingprogramme. Instead of using a series of formal lessons health and nutrition

education took place in the informal atmosphere of the antenatal clinics. While examining pregnant women TBAs were taught to ask questions such as: "Why am I examining your abdomen? What do I find out?" If the pregnant women could not answer a question, they enjoyed knowing the answers a next time. "This kind of game played every second week at the clinic established antenatal care as a routine activity within the community." "In this way mothers became involved in an active learning process directly related to the factors influencing their own health and that of their children." In addition the TBAs made a number of suggestions leading to significant changes in the emphasis of certain aspects of the programme.

Evaluation after three years of project implementation (1980) revealed that the TBAs had established themselves as key health workers in the community. They conducted 56% of deliveries. In addition they were giving antenatal care to 70% of the mothers, postnatal and neonatal care to 77% of mothers and children in the project area. There were significant changes in maternal health care among mothers which indicated an improvement in the health awareness and practices of the mothers in the villages. There was a sharp decline in the maternal mortality rate (MMR): from 12 (1977) to 4.5 per 1000 live births (1980), and the infant mortality rate (IMR) was reduced by 33%: from 123.2 (1977) to 81.5 per 1000 live births (1980). There was an improvement of the nutritional status of under-fives: "A 75% drop in the number of children suffering from third degree malnutrition." (Chand/Soni 1983)

4.3.3 In Latin America

Review of the literature revealed that TBAs were given formal training in Bolivia, Brazil, Colombia, Costa Rica, Dominican Republic, Ecuador, El Salvador, Guatemala, Haiti, Honduras, Mexico, Nicaragua, Panama, Paraguay and Peru (Pillsbury 1982).

Training of TBAs in *Ecuador* has been initiated in 1976. The general objective was to reduce maternal and child morbidity and mortality. In addition it was hoped that births and deaths would be registered and information obtained on morbidity and mortality in rural areas. More specific objectives were: 1) promoting the demand for health services in the community, 2) educating pregnant women and mothers about basic care for themselves and their newborns, 3) achieving effective coordination between the local health unit and the community and developing health programmes. The trainingprogramme for TBAs usually lasted 10-15 days. The course content was divided into 3 principal units: 1) promotion work, 2) practical delivery care, 3) system for referral to health service facilities (see Table 4.3.3a for details). The training course included basic instruction on parental responsibilities, family planning and spacing, birth control methods and the importance of referring people interested in birth control, but the TBAs were not allowed to supply contraceptives. After completing the course the TBAs received a work satchel with the instruments needed for conducting home deliveries. In addition they were given an identification card which had to be renewed every year on the basis of a physical check-up and an evaluation of the services rendered.

Table 4.3.3a Course content of a 10-15 days trainingprogramme (divided into 3 'units') for TBAs in Ecuador

Promotion unit (taking 20% of the training time)	Discussion and the acting out of short dramatized social situations aimed at encouraging the use of health service facilities. Teachingabout the early detection of pregnancy for referral and the importance of referring recent births, nursing infants, preschool children, and requests for family planning to the health service facility.
Unit on practical delivery care (taking 70% of the training time)	Instruction and demonstration on all aspects of pre- and postnatal, delivery, and newborn care. Demonstration techniques were repeated by the TBAs. In this unit supervised practice in rural settings was also given.
Unit on system for referral (taking 10% of the training time)	Practical exercises concerning the referral to health service facilities.

Source: Baquero et al. 1981

A study has been conducted in Ecuador in 1979 on the performance of trained TBAs.
Evaluation revealed that trained TBAs were able to recognize most of the usual signs and symptoms of early pregnancy and its complications and indeed referred pregnant women with complications to health facilities. However in general the trained TBAs did not perform the practices they learned in training. They continued to use the traditional methods (Baquero et al. 1981).

In the region of San Marcos in *Guatemala* a trainingprogramme was initiated in 1976. The training classes lasted from 2 weeks to 6 months depending upon the intensity and the intervals of the classes. The course content covered four general topics: 1) general hygiene, 2) midwifery kit, 3) teaching about pregnancy, and 4) general facts about birth (see Appendix 1d for details).
Trained TBAs (n=20) were interviewed by Greenberg (1982) in order to evaluate their performance. However it was stated that the data were collected in a very short time. In addition the sample size of the TBAs was far too small for statistical analyses and the real behavior of the TBAs might have diverged from their statements about their practices and beliefs. Still Greenberg was confident that, since "the data were consistent with reports from pregnant women and anthropological accounts written about the area and because the TBAs were frank," the data represented both stated and actual behavior.
Evaluation revealed:

- the TBAs indicated that they had learned new principles, techniques and theories about hygiene, nutrition, pre- and postnatal care (cleanliness, and nutrition being the two most commonly cited innovations) and were prepared to implement them, but that the actual acceptance of these practices both by the TBAs and their clients appeared to be another matter.
- the TBAs stated, for example, that women preferred to give birth kneeling, rather than lying in bed, as instructed during the training course. Or, women

refused to be shaved before and after birth, as taught. Or, women complained about the plastic sheet which the trained TBAs placed underneath and on top of them.
In addition women complained that they no longer received the services of the TBAs which they had got before the training such as massages with warm oil [used to loosen the abdomen to make the delivery easier], or 2-3 'temescal' baths [sweat baths used to heat the body].

- the TBAs indicated that it was difficult to refer women to the health centres as the women appeared to distrust the local centres and felt alienated from them:

> "this is in part due to their own fear and modesty, and also to their husbands' jealousies and distrust of other men [male doctors; YL]. It also arised from the condescending and denigratory attitudes towards them and is further compounded by the communication barriers (many women are monolingual Mayan speakers while health post employees speak only Spanish). Their discomfort also stems from their different views regarding health, pregnancy and the process of childbirth."

In addition it has been reported that the discrepancy between services demanded and those delivered had resulted in a widespread use of untrained TBAs. 90% of the trained TBAs reported that women requested untrained TBAs for attendancy at delivery more often than trained TBAs because they charged less, they washed women's clothes, and (as mentioned above)they felt more comfortable with the old ways and did not want to go for check-ups in the health centres or posts (Greenberg 1982).

In 1975 a pilot scheme to train TBAs was carried out in rural areas surrounding the city of Fortaleza in Northeast *Brazil.* Selected TBAs were chosen to attend deliveries in small obstetric units provided by their communities instead of attending deliveries in the womens' homes. A course consisted of five or six one-hour classes. Unfortunately the course content has not been described in details, but it was stated that the classes included discussions and short lectures on physiology, delivery, care of the newborn, recognition of complications, and hygiene. In addition after completing the classes each TBA spent a probationary period of three to four days at an obstetric unit in the community.
Evaluation of the performance of the trained TBAs focused on their referrals to the health service facilities revealed that TBAs were taught to refer women who have a prenatal problem (especially eclampsia or haemorrhage), a complication of labour (including placenta praevia or placental abruptio), malpresentation, and cases of cord or limb prolapse. In addition they were taught to consider women under age 19 or over 35 for referral.
Evaluation revealed that the trained TBAs always referred women with the most serious complications. Women with less serious problems (including breech presentations) were occasionally referred. "The system of referral to the hospital was designed to allow the TBAs to attend uncomplicated deliveries and to refer women with complications. In general, this is what they did." (Janowitz et al. 1985)

4.4 Discussion

In the early trainingprogrammes – before 1972 – training in *hygiene* played a major part as it was assumed that a large proportion of infant death could be averted by clean hands and the use of sterile instruments. After 1972 *family planning* and *referral of women to health centres* became significant components of the trainingprogrammes for TBAs. With the introduction of *Primary Health Care* 'articulation' of the services of the TBAs with those of the formal health services was recommended by WHO (1979). The descriptions of several trainingprogrammes in Africa, Asia and Latin America revealed that this has not (yet) been realised (see 4.3). However we are fully aware of the limitations of these evaluations as they appear to be restricted and methodologically of questionable value. In addition refresher courses have not been reported (only the *need* for these courses in Liberia and Thailand) and supervision of the trained TBAs has been minimal (as has been reported from Sierra Leone, Liberia, Thailand, the Philippines, Ecuador and Guatemala). Therefore we cannot estimate the effect of the trainingprogrammes *in the long term.*

The descriptions of the programmes show that the impact of training is questionable. In a few places training has been reported as partly successful because trained TBAs increased their antenatal activity and referred more women to the health centres (in Ghana [Accra Region; Volta Region] and in India [Maharashtra State]). However, in several places training did not succeed as trained TBAs reverted to their own traditional practices (as has been reported from Ghana, Liberia, Sierra Leone, Ecuador and Guatemala). It is also evident that the clients of the TBAs play an important role as they may respond negatively to the training. In Sierra Leone villagers had raised expectations of the new skills of the trained TBAs. They condemned them for the limitations in their methods. In Ghana the community had high expectations of the trained TBAs. They expected better services as they saw the TBAs as part of the health system. In Guatemala women did not want to accept the new practices of the TBAs and obviously preferred the attendance of untrained TBAs.

It is evident that in all three continents mostly short training courses [which lasted from a few days to some weeks] have been given, and are still given. Course contents of trainingprogrammes in Sierra Leone, Liberia, Thailand, the Philippines, Ecuador and Guatemala show that TBAs have to learn and get used to many different topics commonly taught in Western countries within a short time. This must be a very difficult, if not impossible, task for TBAs who are mostly old, with poor vision (as has been reported from Thailand), illiterate and not accustomed to this. Moreover the way of teaching (giving lectures, demonstrations etc.) and the teaching materials appear to be 'Western' and, as Jordan (1989) has emphasized, thus unsuitable for TBAs. In the reports of the trainingprogrammes there was hardly any remark about the didactic consequences of the training. It was only Greenberg (1982) who directed the attention to it by stating that "since most of the TBAs are illiterate, and learn everything they know by participant-observational methods, perhaps a classroom approach is not the most effective pedagogical vehicle".

All these facts – resulting from the cultural difference between Western educated trainers and locally educated TBAs (and their clients) – have obviously not been

taken into account in assessing the value of the trainingprogrammes. Only one trainingprogramme could be traced which takes these facts into consideration. In India [Maharashtra State] the cultural differences between trainers and TBAs (with their clients) were taken as a fact and therefore a very sensitive problem-solving approach to the training aiming at bridging the cultural gap was adopted. Because of this principle it was, for example, successfully accomplished to discourage a practice which was considered to be harmful while avoiding the creation of psychological barriers to change. Trying to find a way of dealing with the cultural differences between trainers and TBAs underlines the remark of Greenberg (1982) that "for any health intervention to be effective, one must treat both indigenous and Western practices as cultural systems which require mutual understanding and accomodation".

'Akua'ba' doll
Fertility figure
Asante, Ghana
Wood and beads
H. 28 cm

'Gelede' breast and belly plate
Yoruba, Nigeria
Wood
H. 41,5 cm

Ritual figure
Senufo, Ivory Coast
Wood
H. 34 cm

Mother and child figure
Senufo, Ivory Coast
Wood, patina
H. 76 cm

'Lefem' mother and child figure
Bangwa, Cameroun
Wood
H. 88 cm

Funerary figure
Yombe, Congo
Wood with white, black and rust-coloured paint
H. 52 cm

'Odudua' mother and child figure
Yoruba, Nigeria
Wood with red paint, patina
H. 67,5 cm

'Epa' mask
Yoruba, Nigeria
Wood with white and blue paint
H. 114 cm

5 Field Study in Ghana

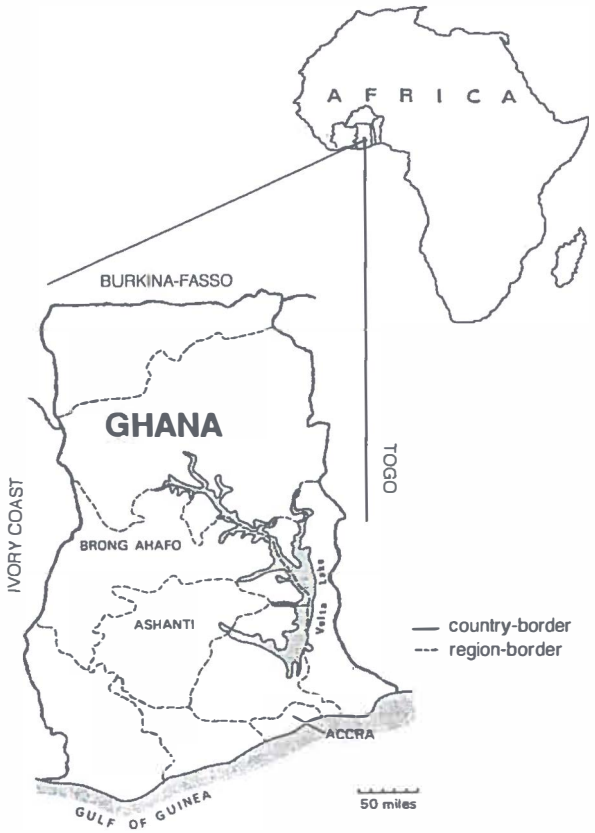
5.1 Introduction

In 1978 (the year of the International Conference on Primary Health Care in Alma Ata [former USSR] – see 4.3) the Ministry of Health (MOH) in Ghana introduced the Ghana Primary Health Care Strategy (GPHCS). Training of TBAs formed an important part of this programme. Before starting the training of TBAs all over the country two pilot projects were inaugurated in two different regions*: the Danfa Comprehensive Rural Health and Family Planning Project in Greater Accra Region and the Brong Ahafo Rural Integrated Development Project in the region Brong Ahafo. From the experience gained from these projects the MOH decided in 1979 to introduce the GPHCS in one district per region. However, the trainingprogrammes were hard hit by a severe decline in the Ghanaian economy which characterised the late 1970s and early 1980s. In the mid-1980s, when the economy improved, the MOH decided to implement a National TBA Programme. Again pilot projects were set up (see 4.3.1). Using results and findings obtained from these projects, training of TBAs in all the regions was started in 1989, and is still continuing. A medical anthropological study of the role, practices and beliefs of TBAs was carried out by the author in 1979/1980 in Ashanti Region (see map pg. 118). In this region the hospital in Agogo town – which is the biggest town in the district Asante Akim – was in 1979 assigned by the MOH to introduce PHC in Agogo and the surrounding villages. The District Medical Officer (DMO) who was in charge of Agogo Hospital at that time started an initial survey as a pilot project in the district in order to collect data about TBAs. 29 TBAs were interviewed in 18 villages throughout the district. However, the results of the survey did not solve how a trainingprogramme for TBAs should be formed: more detailed information about TBAs was required and the DMO requested the medical anthropological study. Because of transport problems the study was restricted to Agogo town (see map pg. 129).

5.1.1 Country profile

Ghana is situated on the Gulf of Guinea in West Africa and is bounded on the south by the Atlantic Ocean, on the west by the Ivory Coast, on the north by

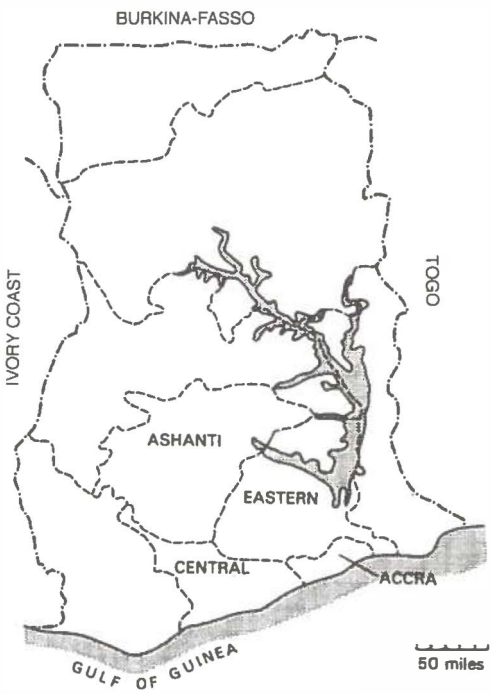
* Ghana is administratively divided into regions which are subdivided into districts.



Burkina Faso and on the east by Togo. The country has a north-south distance of about 450 miles and extends about 250 miles from east to west. Geographically from south to north one can distinguish: a narrow coastal strip of savanna land, a broad tropical forest belt (about one third of the country), and the northern savanna area. The Volta Lake created by construction of the Akosombo Dam in the Volta River in the mid-1950s, has become the largest manmade lake in the world. Administratively Ghana is divided into nine regions (see map, pg. 104) which are subdivided into districts: an average of seven districts each with populations ranging from 150 to180 thousand per district.

The total population of Ghana has been estimated at about 14.0 millions (1986) and has increased during the last years with an annual growth rate of 3.3% (1980-85)(UNICEF 1988). The population growth rate is similar to other sub-Saharan countries of Africa (Table 5.1.1). However after Nigeria Ghana is the second most densely populated country in sub-Saharan Africa. The population is concentrated in the mid-southern part of the country where 52% live on 24% of the total surface area (see Figure 5.1.1).

Figure 5.1.1 Four administrative regions (Ashanti, Eastern, Central, Accra) in Ghana constituting 24% of the total surface area in which 52% of the total population lives
Source: Hogerzeil 1985



About one third of the population lives in communities of over 5000 people. Average annual growth of urban population has been estimated 3.9% over the period 1980-85; 48% of the urban population lives either in the agglomerations of Accra (one million inhabitants in 1982) or Kumasi (400.000 in 1982)(see map pg. 129). However, it should be realised that many Ghanaian towns are in fact semi-urban settlements rather than organized cities (Morrow in Morley 1983; Hogerzeil 1985).
More than 60% of the population maintain adherence to traditional religions, 20% are Christians (mainly in the South) and 12% are Muslim (in the North). Ghana has a high literacy rate compared to other sub-Saharan countries of Africa as about 75% of the school-age children receive a primary school education, while more than 35% receive a secondary school education (Table 5.1.1).
In 1957 Ghana was the first African country to achieve independence from colonial rule.
In 1966 the president of the country, dr. Kwame Nkrumah, was toppled in a coup led by the army and the police. In the following years four more military coups took place and from 1981 until now the country has been governed by a Provisional National Defence Council (PNDC) under the leadership of Flight Lieutenant Jerry Rawlings.

Table 5.1.1 Demographic indicators of selected countries of sub-Saharan Africa

Country	Total population (millions) 1986	Population annual growth rate (%) 1980-85	Average annual growth rate of urban population (%) 1980-85	% of grade 1 enrolment completing primary school* 1980-86	Secondary school enrolment ratio* 1983-86 male/female
Benin	4.2	3.1	4.4	15	29/12
Botswana	1.1	3.5	4.5	80	27/31
Burkina faso	7.1	2.6	5.3	75	7/3
Cameroon	10.2	3.2	7.0	70	29/18
Côte d'Ivoire	10.2	3.8	6.9	89	27/12
Ghana	14.0	3.3	3.9	75	45/27
Kenya	21.5	4.1	6.3	62	25/16
Liberia	2.3	3.4	4.3	....	33/13
Nigeria	98.5	3.3	5.2	31	..../....
Senegal	6.6	2.9	4.0	86	18/9
Sierra Leone	3.7	2.6	5.1	48	23/11
Tanzania	23.3	3.5	8.3	76	5/3
Togo	3.1	3.3	6.4	43	33/10
Uganda	16.0	3.0	3.0	58	11/5
Zaire	30.9	3.0	8.4	65	81/33
Zambia	6.9	3.5	5.5	85	23/13
Zimbabwe	9.1	3.7	5.0	79	56/38

* Children completing primary school: percentage of the children entering the first grade of primary school who successfully complete that level in due course. Primary and secondary enrolment ratios: the gross enrolment ratio is the total number of children enrolled in a schooling level – whether or not they belong in the relevant age group for that level – expressed as a percentage of the total number of children in the relevant age group for that level (UNICEF 1988)
Source: UNICEF 1988

As far as the economy is concerned the largest industry is VALCO (Volta Aluminium Company) powered by the electricity generated at the Akosombo Dam, but the major occupations continue to be: traditional farming, fishing along the coast, and trading. By far the largest source of foreign exchange for the country is the export of cocoa*; timber is the second. By the early 1980s priority has been given to rehabilitate the cocoa, mining and timber industries and to improve the transport network which had almost fallen apart. However, in the same period the country suffered from chronic food and fuel shortages and in 1983 unforeseen circumstances formed a set-back for the programme of the Government as Nigeria expelled an estimated one million Ghanaians contrary to the conventions of

* Cocoa is an important cashcrop of Ghana for many years: it was introduced into the country in 1879, and during the early 20th century the Gold Coast [called Ghana after independence] became the world's largest producer of cocoa (Crowder 1977).

ECOWAS [the Economic Community of West African States] which created chaos and food shortages. This situation was made worse by a drought seriously affecting cocoa and agricultural production, leading to a foreign exchange crisis and an alarming drop in the level of Lake Volta (which lead to the shut down of four of the six generators at the huge Akosombo power station). But 1984 was a year of good rains enabling agriculture and industry to recover. It is expected that Ghana will continue to be heavily dependent on foreign aid (Crowther 1989).

5.1.2 Health care in Ghana

The health problems in Ghana are more or less similar to those in most countries in Africa. The major causes of morbidity and mortality in the general population are communicable diseases such as malaria, measles, tuberculosis, onchocerciasis, and tetanus. In addition there are non-communicable disease problems like sickle-cell disease, cirrhosis, hypertension and stroke. The morbidity and mortality of children under five are mainly caused by malnutrition, diarrhoea, pneumonia, malaria, measles or whooping cough; frequently children suffer from several of these conditions at the same time. In 1986 the under-five mortality rate (U5MR)* has been estimated to be about 150/1,000 live births: this means that Ghana belongs to the countries with the highest U5MR** (UNICEF, 1988). In 1976 the overall infant mortality rate (IMR)*** has been estimated to be about 130/1,000 live births, but with a wide variation in the different regions (see Figure 5.1.2) ranging from 63/1,000 in the Greater Accra Region to over 200/1,000 in the Upper Region (Morrow in Morley 1983).

Figures for 1986 indicate an estimated overall IMR of 91/1,000 live births. This means that compared to the estimated IMR in 1976 (130/1,000) the annual number of deaths of infants has declined within the last decennia. However, an IMR of 91/1,000 live births is still high, and characteristic of most sub-Saharan countries (Table 5.1.2).
Maternal mortality rates**** in 1976 range from an observed 500/100,000 live births under hospital conditions to an estimated 1800/100,000 live births in rural areas (Morrow in Morley 1983). Figures for 1980-84 indicate an estimated overall MMR for Ghana of about 1074/100,000 live births. This is about 100 times higher than the estimated MMR of some Western countries (e.g. USA 9/100,000 live births; UK 7/100.000; France 13/100,000; Japan 15/100,000). In addition it should be remarked that the MMR for Ghana has not changed very much since

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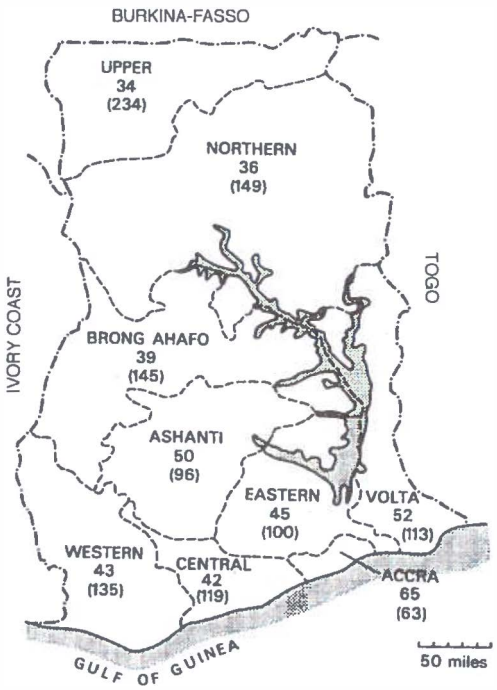
* Under-five mortality rate (U5MR) = annual number of deaths of children under 5 years of age per 1,000 live births.

** Vety high U5MR countries: over 170/1,000; high U5MR countries: 95-170/1,000; middle U5MR countries: 26-94/1,000; low U5MR countries: 25 and under/1,000 live births.

*** Infant mortality rate (IMR) = annual number of deaths of infants under one year of age per 1,000 live births (UNICEF 1988).

**** Maternal mortality rate (MMR) = annual number of deaths of women from pregnancy related causes per 100,000 live births (UNICEF 1988)

Figure 5.1.2 Expectation of life and (infant mortality rates) (Ghana 1976)
Source: Morrow 1983



1976. Compared to other sub-Saharan countries the MMR for Ghana seems to be very high* (UNICEF 1988).

5.1.2.1 Health facilities in Ghana

According to information from the Ministry of Health (MOH)(1983) the total number of hospitals in the country is 106, of which 51 are governmental hospitals including 2 University hospitals and 55 non-governmental hospitals (20 para-governmental and mines hospitals, while 35 are church-related). In addition there are health centres (managed by medical assistants) and health posts (managed by nurses). The (para)governmental hospitals are concentrated in the four most densely populated regions (see Figure 5.1.1)(Hogerzeil 1985).
In 1976 the MOH established a health planning unit (HPU). As it was recognized that the health of the people depended on many factors outside the direct control of the MOH, the Planning Unit developed early relationships with other Ministries, particularly the Ministries of Economic Planning and of Finance. One of the basic principles of the Health Planning Unit (HPU) was: "Effective planning requires contributions from all levels in the system. Policies, guidelines, overall

* Care must be taken with inter-country comparisons of MMR as the figures may be rather crude and inaccurate and may not have been collected on a comparable basis (Kwast 1988).

Table 5.1.2 Health indicators of selected countries of sub-Saharan Africa

Country	Infant mortality rate (under 1)		Under 5 mortality rate		Maternal mortality rate (/100,000)
	1960	1986	1960	1986	1980-84
Benin	185	112	310	189	1680
Botswana	119	69	174	96	300
Burkina Faso	220	141	388	241	1500
Cameroon	163	96	275	158	141
Côte d'Ivoire	200	102	320	153	.....
Ghana	132	91	224	150	1074
Kenya	124	74	208	118	168
Liberia	180	124	303	211	.....
Nigeria	190	107	318	178	1500
Senegal	180	134	313	227	530
Sierra Leone	225	171	397	297	450
Tanzania	146	107	248	179	370
Togo	182	95	305	157	84
Uganda	133	105	224	174	300
Zaire	148	100	251	166	800
Zambia	135	82	228	132	109
Zimbabwe	110	74	182	118	145

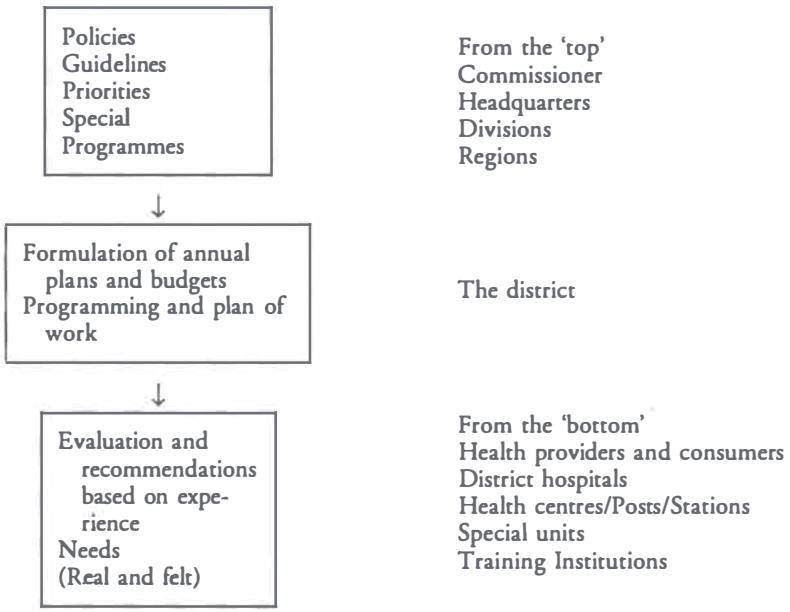
Source: UNICEF 1988

priorities, and strategies must come from the top political and technical echelons, whereas data evaluation and recommendations for operational activities based upon experience must come from the district and community levels." This principle was presented as the 'top-down/bottom-up' planning (see Figure 5.1.2.1a)(Morrow in Morley 1983).

Project teams carried out much of the work of the Planning Unit. "Team members were drawn from senior staff of the Planning Unit and were supplemented by others from the MOH, the University, and other Ministries, thus adding expertise in specific subject areas, creating useful linkages with other groups and increasing the participation of many others in the planning process."

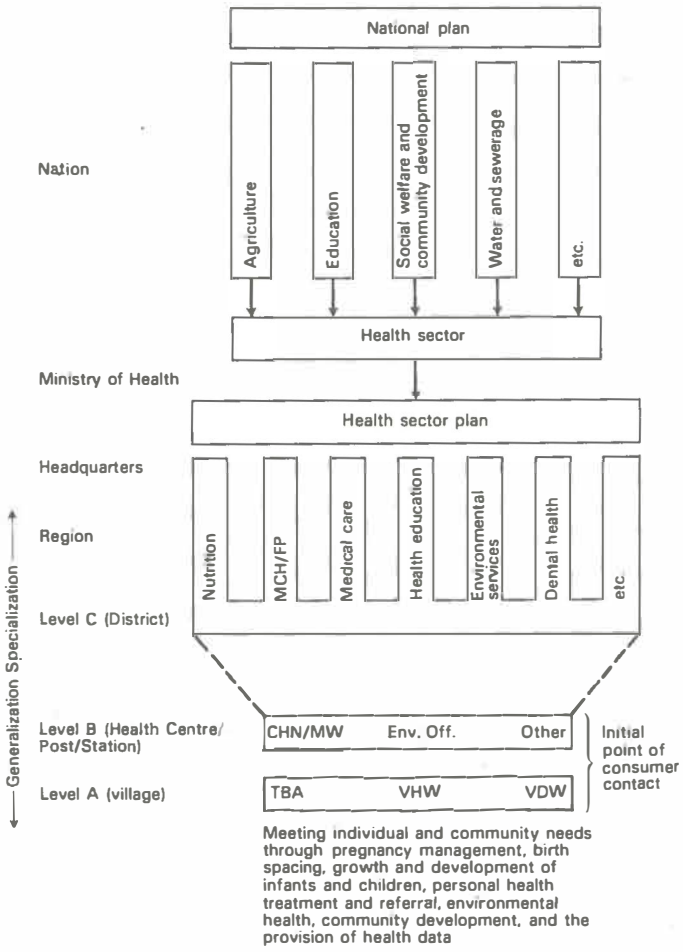
In 1978 a document entitled *"A primary health care strategy for Ghana"* was prepared by the HPU and MOH. Assessment of the general health status of the population had revealed that in the previous ten years there had been hardly any improvement in the infant mortality rate (in 1960 the estimated IMR was 132/1,000 and in 1976 130/1,000 live births), the maternal mortality rate (see page 121) or in communicable disease rates. The document gave the following analysis of this evaluation: "The basic reason is that the health services have been doing the wrong things because of misplaced priorities. The existing health services system funnels resources towards the minority of the population having access to hospital-

Figure 5.1.2.1a 'Top-down/bottom-up' planning. (From: An Approach to Planning the Delivery of Health Care Services. Manual No.1 National Health Planning Unit, MOH Accra, Ghana 1979)
Source: Morrow 1983



based services which cater to specialized health problems." Four conditions have been identified "as the root cause of this situation: 1) emphasis on the construction of facilities rather than the provision of services, 2) over-sophisticated training with emphasis on specialized hospital-based services for the few, rather than preventive and promotive services for everyone, 3) poor and unequitable deployment of health staff, 4) a 'top-down' health care delivery system with a noticeable lack of coordination with other sectors (social welfare and community development, water and sewerage, agriculture, etc.) and little or no community involvement".
In 1978 the Planning Unit started to develop more active cooperation and interchange with the Ministry of Local Government, the Department of Social Welfare and Community Development, the Ministry of Education, the Ministry of Agriculture, the Ghana Water and Sewerage Corporation and others. A general framework of the primary health care system based upon a three-tier system (see Figure 5.1.2.1b) was planned:

Figure 5.1.2.1b The integration of health services. [For abbreviation in the figure, see text]. (From: Planning and Management of Health Services at the District Level. Manual No. 2. National Health Planning Unit, MOH Accra, Ghana 1979)
Source: Morrow 1983



1 Level A (community level): at this level community health workers selected by the community itself work, but these are trained by the MOH in primary and promotive procedures for simple curative measures, with emphasis on pregnancy management, child health promotion, environmental protection, and mobilization of health-related community projects. There are at least two level A workers: the TBA and the village health worker (VHW). A third function, organisation for community development, may involve a village development worker (VDW).
2 Level B: community health nurse-midwives (CHN/MW) and community environmental development officers (Env. Off.) who have additional minimal training in therapeutic procedures work at this level.

3 Level C (district level): a district health management team, consisting of a district medical officer who has special postgraduate training along with a district public health nurse, a district health administrator, and a district health inspector work at this level. The team works in direct relation with the district chief executive to facilitate an integrated approach to total community development. In addition each district has a small team of medical field unit personnel trained for communicable disease surveillance (Morrow in Morley,1983).

The Planning Unit recommended "the recruitment and training by the year 2000 of 22,000 community-level primary health workers who would be selected and supervised by village development committees and who would be involved in pregnancy management, first-level medical care, environmental sanitation, health education and the mobilization of health-related community projects". As it was recognized that practitioners of traditional medicine are central personnel in the delivery of PHC for rural populations the MOH strongly supported training-programmes for TBAs (Warren/Tregoning 1979).

5.1.3 Characteristics of TBAs in different parts of the country

As mentioned before two pilot projects [the Danfa and the BARIDEP project] were inaugurated before starting trainingprogrammes for TBAs all over the country in 1979. These programmes were hit by a decline in the economy, but when the economy improved a National TBA Programme as well as new pilot projects were set up in the mid-1980s (see 4.3.1 and 5.1). From the study areas of the National TBA Programme data were gathered on the characteristics and practices of the TBAs. The findings will be summarized here.

Results of the registration of 263 TBAs in the *Greater Accra Region* as part of the Danfa project showed that the typical TBA was 62 years old, had been in practice for 23 years and performed only 7 deliveries per year. The ratio of TBA's to population was 1 to137; 48% were men (see 1.3.2). Approximately 60% turned out to be 60 years or older. Less than 3% of the TBAs performed more than 30 deliveries annually while nearly 50% performed less than 4 deliveries (Table 5.1.3). Interviews with 82 out of 263 TBAs revealed that farming was their principal occupation (67% of the TBAs) and that most TBAs (94%) were illiterate. They learned their practices by joining usually a parent or a grandparent. There were two types of TBAs: herbalists [79% of the male TBAs and 11% of the female interviewed] who were engaged in midwifery as part of their medical practice and those who limited their practice to midwifery. The male TBAs averaged 8.5 deliveries per year; female TBAs 4.4 Most female TBAs (87%) delivered only women from their own village, but 25% of male TBAs "had clients from more than a 8 km radius." The herbalists provided prenatal care and "were more likely to attempt to treat complications of pregnancy and delivery." The TBAs who limited their practice to midwifery generally did not provide prenatal care; only a few of the TBAs stated that they gave nutritional advice during pregnancy. "They were usually called after labour had begun; then they determined the onset and course of labour by inquiring about the contractions, bleeding or rupture of the

Table 5.1.3 Distribution of TBAs by age group and number of deliveries performed annually as reported in 1972 registration, in a rural area in southern Ghana

Age group (years)	No. of deliveries performed annually 0-4	5-9	10-19	20-29	30+	not reported	Total No. (%)
20-39	5	2	1	–	–	–	8 (3.0)
40-49	27	9	5	1	–	3	45 (17.1)
50-59	22	16	8	2	3	3	54 (20.5)
60-69	31	27	8	4	–	2	72 (27.4)
70+	35	34	9	2	4	–	84 (31.9)
Total No.	120	88	31	9	7	8	263 (100.0)
(%)	(45.6)	(33.5)	(11.8)	(3.4)	(2.7)	(3.0)	

Source: Nicholas et al. 1976

membranes and by palpating the abdomen for contractions or position of the head. Only 2% performed any vaginal examinations in order to determine the descent of the head." The mothers delivered in the squatting position and as they strained during the second stage of labour fundal pressure was exerted. 39% of the TBAs gave herbs during labour to increase contractions and speed delivery. Several causes of prolonged labour were mentioned: a small pelvis, disease in the mother, inability of the mother to push because of pain or fatigue, unfaithfulness on the part of the mother or argument between the parents. Disease in the womb of the mother and excess blood in the mother were mentioned as reasons for heavy bleeding during labour. Generally the TBAs did nothing to prevent tearing of the perineum which was believed to be caused by a large infant or a small outlet. Tears of the perineum were treated with a hip-bath into which salt, herbs, camphor balls or antiseptic was added. 58% of the TBAs gave herbs in cases of postpartum haemorrhage, 50% referred to the hospital and the others tried a herbal treatment first and if this did not work they also referred. The umbilical cord was cut with a razor blade (mostly new), a knife, broken glass, or scissors. Usually these instruments were not washed or sterilized. The TBAs dressed the cord with a mixture of herbs and salt, or other materials like talcum powder, clay, palm kernel oil, and ground shells. (Animal dung was rarely used in this area). Respiratory problems of the infant at birth were believed to be caused by fatigue of the infant; immediate care of the asphyxiated newborn existed of pouring cold water on the infant, slapping the buttocks or smearing irritating herbs on the skin. Most of the TBAs (75%) did not routinely prescribe medicines for infants; the others prescribed herbs, castor oil or glucose. Breastfeeding was generally advised; 29% gave advice on infant feeding during the first week of life usually recommending sugar water, coconut water or diluted milk as supplements. The majority of the TBAs did not take care of the infant after the first week of life, while 15% occasionally gave some advice (Nicholas et al. 1976).

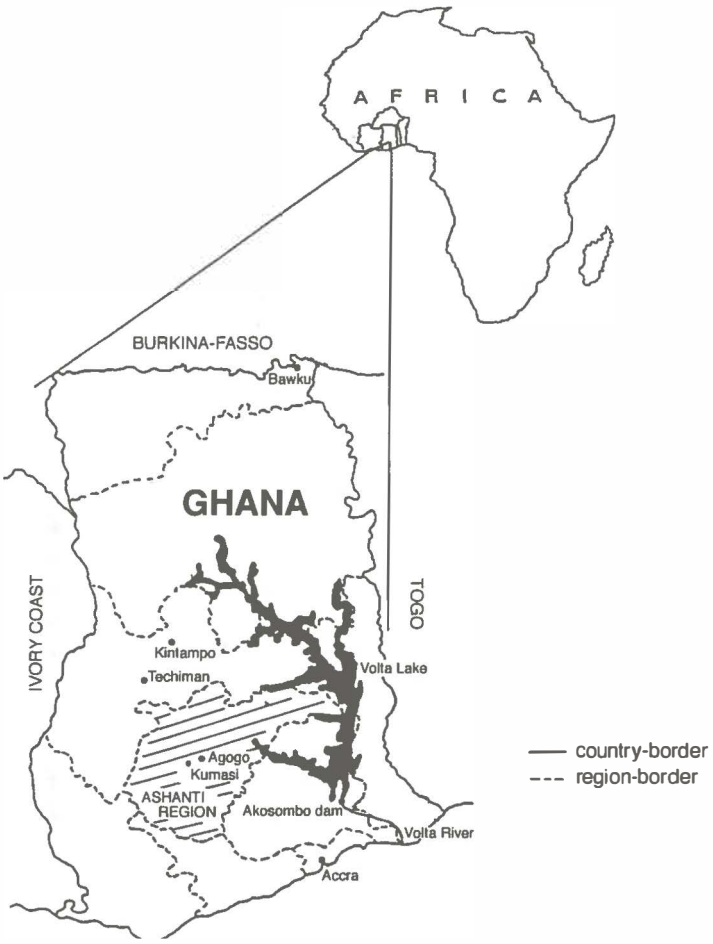
The interviews with TBAs of one district *in each of the10 regions of the country* as part of the National TBA Programme (see 4.3.1) revealed that the TBAs were generally older women (with an average age of 50 years, ranging from 40 to 80

years), illiterate, and had other roles in the community such as farming. Most of them had acquired their skills from their mothers or other female relatives through apprenticeship; some claimed that they received their skills as 'a gift from God'. Some added herbal or spiritual treatments to their practice. Most TBAs delivered one to five babies per month; for each delivery they received fees in cash or in natura (kerosene or soap).
In the pilot project of Dangbe District in the *Greater Accra Region* (where *trained* TBAs were interviewed – see 4.3.1) findings about the characteristics of TBAs showed that the mean age was 57 years ranging from 29 to 80 years. 22.9% was under 50 years. This high incidence is probably due to the fact that the project encouraged the recruitment of TBAs' assistants as well. 29.7% of the TBAs were men. The majority of the TBAs (59.5%) practiced straight midwifery; 21.6% added spiritual practices and 18.9% were herbalists. The TBAs reported a mean of 3.4 deliveries in the month prior to the interview while 68.5% reported 3 or less deliveries. This is similar to the number of deliveries performed monthly as has been reported from the National TBA Programme (see above), but in comparison with the number of deliveries performed annually as shown in Table 5.1.3 this seems rather high. Most TBAs (75%) reported that they delivered the mother in the squatting position; the rest requested the mother to lie down. They all stated that they encouraged the mother to push when the head of the infant appeared, when the amniotic fluid was lost, or when the mother started to shiver and sweat. All of the TBAs experienced various complications of delivery such as cord around infant's neck, respiratory distress, retained placenta, arm or leg presentation, postpartum haemorrhage, breech presentation and cord presentation. TBAs stated that they were able to handle some of the complications. For example, when faced with a delivery with a cord around the infant's neck the TBAs said that they would unwrap the cord. The immediate care of the asphyxiated newborn consisted of e.g. sprinkling cold water or alcohol on the infant's body or rubbing its back. When faced with postpartum haemorrhage they sometimes gave herbal treatment. A retained placenta was managed either with herbal treatment or massage of the abdomen. They also referred to a nearby health post.
The interviews with 48 *trained* TBAs in the *Volta Region* (see 4.3.1) revealed that the mean age was 55 years, ages ranging from 25 to 80. The majority were between 50 and 65 years. 89.6% of the TBAs limited their practice to midwifery, rather than being herbalists or spiritualists. 41.3% had been to school, "most likely the younger ones". Except for one all TBAs were women.

5.1.4 Study area

5.1.4.1 AGOGO TOWN IN THE DISTRICT ASANTE-AKIM

Asante-Akim is a district with approximately 183,000 inhabitants. It is situated in the forest-zone. There are 62 villages with more than 200 inhabitants each. Most of these villages are difficult to reach due to bad road conditions, especially in the rainy season. The only tarred roads are the Kumasi-Nkawkaw highway which is part of the south-north highway Accra-Bolgatanga (see map pg. 132) and the Konongo-Agogo road. Farming is the main source of income. People cultivate different crops such as cassava, plaintain, coco yam and cocoa in small areas in the



forest. The cultivation is mainly done by women. The local government of the district consists of three councils – situated in three different towns of the district –: the Konongo Odumasi Urban Council, 2) the Asante-Akim Local Council, and 3) the Juaso-Bankaman Local Council. Each council has to take care of maintaining the social services in their own area such as maintenance of the roads, the schools, the cemetery, the slaughter houses and meat stores, the markets and lorry stations, the supply of water and electricity, the maternity clinics and the dressing stations, the collection of taxes, and maintenance of the law. Most people of the district Asante-Akim are Asante (or 'Ashanti') (see 5.1.4.2).

Agogo town with about 46,000 inhabitants is the biggest town in the district. The Asante-Akim Local Council, which is situated at Agogo takes care of the social

services in the town and surrounding villages. There are three important churches in Agogo: the Presbyterian Church, the Roman Catholic Church and the Methodist Church. Most of the inhabitants belong to the Presbyterian Church. The three churches have both primary and middle schools. The Apostolic Church has also a primary school. Apart from these schools (a total of 5 primary and 7 middle schools) there are also the Collins Commercial College, the Presbyterian Women's Teacher Training College,the Agogo State Secondary School and the Presbyterian Nursing Training College (Agyekum 1979).

5.1.4.2 THE ASANTE PEOPLE

The Asante belong to the 'Akan', the largest population group of Ghana (44%). 'Akan' is a collective noun for a number of ethnic groups in southern Ghana who are closely related and probably have a single origin: the Asante, Fante, Bono, Akyem, Kwahu, Akwapim, Nzima, Ahanta, Assin, Brong, Denkyira, Etsii, Sefwi, Twifo and Wassaw. These groups speak virtually identical dialects of the tonal language Twi and share many cultural similarities. Among the Akan the fundamental unit of social, jural and political organisation is the *abusua,* the matrilineage. This is a group of people who trace their relationship to each other through the female line (initially through their mothers) and see themselves as descended from a common forebearer who lived some time between six and eleven generations previously. Within the *abusua* kinsmen of the same generation are addressed as sibling *(nua),* and kinsmen of the ascending generation as mother *(ena* or *maame)* or as mother's brother *(wofa).* Kinsmen of the descending generation are called 'my child' *(me ba)* by women and 'my sister's child' *(wofase)* by men. Kinsmen of a few generations (seldom more than four) tend to live fairly close to each other in a village and they are headed by a senior man, or elder *(abusua panyin),* and a senior woman *(obaa panyin).* Many Asante women tend to live together with their children and other female relatives separated from their husbands. Property and leadership are passed down from maternal uncle to sister's son. This system of matrilineal inheritance is a dominant feature of the Asante society.

The term *abusua* can also refer to a much wider group than the lineage and is usually translated as 'clan'. Members of one clan are supposed to be descendants of one common ancestress who lived in the distant past. It is not possible to trace genealogical links within the clan and clans have dispersed among all the groups of the Akan. In total there are seven or eight clans among the Akan (Bleek 1976; McLeod 1984). Apart from the matrilineal link between one generation and another the Asante also believe in a form of patrilineally inherited, non-physical link: besides inheriting the mother's blood *(mogya)* every Asante is believed to receive the spirit of the father *(sunsum* or *ntoro).* The *sunsum* is thought to mould the child's individual personality and character. Thus the mother-child bond is considered to be a physical one, the father-child bond is regarded as spiritual. In addition every Asante is believed to receive a *kra.* The *kra* is a life principle given by the Creator to an Asante woman or man when about to be born and with this his or her destiny will return to the Creator when he or she dies (Sarpong 1977).

The attitude of the Asante to fertility has been described by Sarpong (1977) who stated that the ideal of every Asante is to have as many children as possible, that prolific child-bearing is honoured and that parents of large families and mothers

of twins and triplets are held in special esteem. However Bleek (1976 a) has reported that this attitude towards fertility has been the attitude in the past. Nowadays it is no longer an ideal of the Asante to have as many children as possible. As a consequence of social and economic changes children are no longer of economical use, but they cost money. Children need food, schooling and other things. Bleek noted that the prevalent view of Asante people – adolescents as well as adults – is "that ordinary human beings can no longer afford to have large families ... and that it is more praise-worthy to have only a few children and to be able to look after them than merely to have a large family."
Having children in quick succession has been despised in the past. Nowadays this is still condemned. "If a woman bears children at an interval shorter than two years, people tend to talk about it as something exceptional and make fun of it. People who bear children in quick succession are like animals and they cannot control themselves." (Bleek 1976 b in Voorhoeve 1978)*. Bleek (1976 a) has indicated that the rationale behind the disapprovement is the idea that it is hard for a woman to take care of two small children simultaneously.
Abortus provocatus may be practised by Asante women. Certainly female pupils of secondary schools who become pregnant may secretly practise abortus provocatus in order to avoid negative social sanctions of disgrace or being an object of ridicule. Finishing school is considered to be an important way to gain success in life. Officially, pregnant pupils are allowed by the Ministry of Education to continue visiting school or to return to school after the birth of the child. However they mostly don't do this as they feel too embarrassed. In general abortus provocatus is strongly condemned verbally, but it is secretly approved of as long as the abortion is "successful" and is kept secret**. But when the woman dies because of the abortus, everybody will call her "foolish and frivolous". There are several methods of practising abortus provocatus among the Asante: using herbs*** (taken orally as a solution or given as an enema or introduced into the vagina), drinking extremely sweet or alcoholic liquor, doing very exhausting exercise or using medicines and injections bought in small drugstores (e.g. overdoses of *APC* tablets**** or *Alophen*, a laxative)(Bleek 1979; van den Borne 1985; van der Geest 1986).

5.1.4.3 Health facilities in Asante-Akim

At the time of the study the district Asante-Akim had the following health facilities:
- Agogo Hospital (220 beds), with an Under Five Clinic,
- Konongo Mines Hospital (12 beds, private) and Konongo Health Post (Govt.),

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* Voorhoeve (1965) heard the same explanation – *like animals* – for twin-births in Irian Jaya (Western New Guinea).

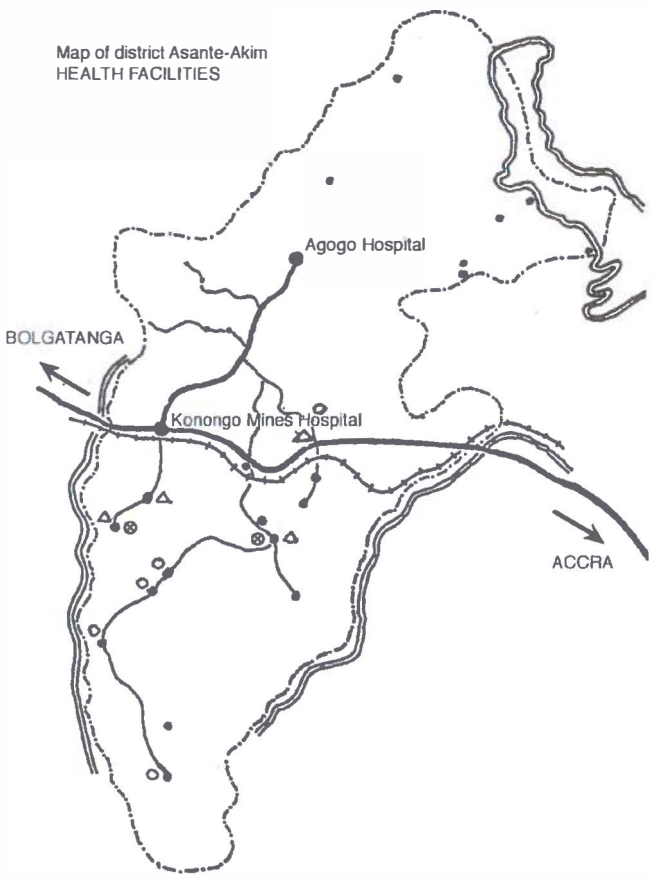
** Korfker (1983) also found this in a village in Senegal.

*** Herbs derived from plants and trees that have been mentioned: passion-flower, mango, papaya, pineapple, cotton-tree, lemon, coffee-plant, coconut and odum.

**** Tablets composed of a combination of Acetylsalicylic acid, Paracetamol and Caffeine, used for pain and fever.

- A few dressing stations established by the Local Council,
- A few private clinics,
- and the services of Community Health Nurses and a few Western trained midwives.

Besides these 'scientific'* medical institutions and practitioners there are numerous practitioners of traditional medicine including the TBAs.



railway
paved road
district border
river
dirt road
= 3,8 km

△ dressing station or local council clinic
○ private clinic
⊗ (professional) midwife

* The term scientific as opposed to traditional medicine is to indicate a view in which the rational explanation of natural events is in terms of cause and effect, while the term traditional medicine is that of service performed through the utilization of magico-religious acts and concepts (Twumasi 1975).

5.1.4.4 AGOGO HOSPITAL

Agogo Hospital belongs to the Presbyterian Church. The hospital was built in 1931 by the Basel Mission. Thirty years later (1961) the hospital has been integrated into the Presbyterian Church. In 1978, the Medical Work Committee of this church proposed to the Ministry of Health to give Agogo Hospital the status of District Hospital. At the end of 1978 the Ministry approved this proposal. This coincided with the introduction of the Ghana Primary Health Care Strategy (GPHCS) (see 5.1.2). As mentioned before it was decided in 1979 that this programme should start in one district per region. For the Ashanti Region the Government did not have a suitable government hospital to start the programme: therefore the non-government Agogo Hospital was given the substantive status of District Hospital for Asante-Akim and was offered the opportunity to start the programme. The District Medical Officer of Health who was in charge of Agogo Hospital at that time initiated a survey in the district (see 5.1) and collected data about TBAs. It appeared that there were many TBAs in a village, each of them doing a few deliveries a year, and that they were generally old and illiterate. More detailed information was required and the DMO requested the medical anthropological study which is described here.

5.2 Aim of the study

The aim of the study was to get information on the role, practices and beliefs of TBAs in Agogo town.

5.3 Methods and subjects

The study was performed during a six month stay (September 1979-March 1980) in Agogo. Because of transport problems (transport was very difficult at that time due to lack of petrol in the country – see 5.1.1) it was decided to restrict the fieldwork to Agogo. As a preparation for the actual data collection it was considered necessary to attend deliveries in the Labour Ward of Agogo Hospital in order to become familiar with obstetrics. The Governmental Birth Registration Office of Agogo was visited in order to obtain information about the number of home and hospital deliveries in Agogo. However, the cards in the Registration Office turned out to be useless because not all women registered the birth of their children; especially the ones born at home were usually not registered probably because the people may not have been well-informed on registration or they just may have forgotten to do it. The Antenatal Clinic (AC) was visited to examine the registration system to get information about women who attended the Clinic and delivered at home or in the hospital. By comparing the bookings on the AC and the number of deliveries in the hospital it was noticed that many women visited the AC and delivered at home.

Data were collected on the practices and beliefs of TBAs, and in addition on the motivation of women to visit the Antenatal Clinic. This was obtained in the following ways:

1 The nurses of the Mother and Child Health Clinic (MCH) ['*Under Fives Clinic*'] were asked to obtain information on age, education, tribe, the number of deliveries and place of delivery of the last born of a randomly selected group of women who visited the Antenatal Clinic and who delivered either at home or in the hospital.
2 Women (n=31) who visited the Antenatal Clinic of Agogo Hospital and who had at least one experience of a delivery attended by a TBA were randomly selected while visiting the MCH. They were interviewed in order to obtain information on their motivation for visiting the Antenatal Clinic. In addition this would give the opportunity to get to know more about the TBAs themselves and the womens' appreciation of the TBAs' practices. These expected clients of TBAs were asked especially about: a) their motivation for visiting the Antenatal Clinic, b) the number of previous deliveries and the place of delivery, c) the TBA who assisted them and the appreciation of the TBA's work, d) some of the TBA's practices and e) the type and amount of remuneration they gave for the TBA's assistance. No control group was obtained.
3 Extensive interviews with TBAs were carried out. Agogo town is divided into 10 sections. In 9 of these sections 17 TBAs were identified within the six months study period;15 TBAs were interviewed, 1 TBA could not be traced at home despite several visits and 1 TBA refused to be interviewed. There was an unknown greater number of TBAs. An attempt was made to select at least 1 TBA in each section in order to gain a sample of the TBAs equally distributed in Agogo. TBAs were traced by asking people in the street. The interviews were carried out in the Twi language with the help of an interpreter: a girl who finished Secondary School and who was Asante by origin, able to speak both Twi and English. The replies of the TBAs were recorded using a pencil and a notebook in order to operate with the minimum of distraction and uneasiness during the interviews. All interviewed TBAs were illiterate. On average each TBA was visited and interviewed three to four times. It was necessary to interview the TBAs a few times in order to gather sufficient accurate data and to have the opportunity of checking the reliability of the replies by repeating the questions during a next interview. The interviews were rather 'open', but it was attempted as much as possible to focus the conversations on aspects pertaining the following issues:
   a their age,
   b the way they had become TBAs,
   c the women they assisted: their clients,
   d the type and amount of payment for their assistance,
   e their contacts with other TBAs,
   f the role of Agogo Hospital in relation to their practices,
   g their practices and beliefs.

   Finally an attempt was made to attend deliveries assisted by TBAs, but, although the TBAs did react positively to the request, they commented that it would be difficult to call in time as the women in labour usually requested the TBA for attendance at the very last moment. No opportunity was provided to attend a delivery assisted by a TBA.
4 In order to get information about TBAs and to find out exactly what relatively highly educated young people of the Akan (see 5.1.4.2) knew and could tell

about TBAs and their practices students (n=60) of Form 5 of the State Secondary School of Agogo (47 male and 13 female, average age 21 years, range 17-29) were selected and requested to give written answers to a few questions concerning TBAs. In addition students (n=31) of the Teacher Training School (all female, average age 21years, range 18-31) were selected and requested to write an essay on everything they knew about TBAs and their practices. All but two students were from Ashanti Region and belonged to the Akan; 2 (male) students were from the Upper Region in the northern part of Ghana belonging respectively to the Hausa and the Maprusi people. The essays of these two students were not included, thus a total of 89 essays offering data about practices of TBAs, appreciation of the work of TBAs and payment for TBAs remained. Unfortunately, it was not recorded whether any of the students had experience with the birthprocess themselves. Most probably the majority did nót, since finishing school is considered to be an important way to gain success in life and pregnant pupils feel too embarrassed to continue school or to return to school after the birth of the child (see 5.1.4.2).

5.4 Results

5.4.1 Questionnaires to women attending the Maternal and Child Health Clinic (MCH) *['Under Fives Clinic']*

Information from the data of women (n=330) recorded by nurses of the MCH [*'Under Fives Clinic'*] was obtained on their age, education, the tribe to which they belonged, the total number of deliveries *(parity)* and the place of delivery of the last born. The women were selected at random. (For that reason it may be assumed that this sample represents the women who visit the Under Fives Clinic). Of the total number of 330 women 265 turned out to be Asante while 65 were from other tribes, but all were living in Agogo town.

Out of 330 women 29 (8.7%) were younger than 20 years old, 186 (56.3%) were between 20 and 30 years and 113 (34.2%) between 30 and 40 years; the age of 2 women was unknown. Out of 330 women 184 (55.7%) never went to school, 133 (40.3%) visited elementary school and 12 (3.6%) secondary school or other schools (training college, commercial, vocational); the schooling of 1 woman was unknown.

316 women (95.4%) indicated that they had visited the Antenatal Clinic, while 13 women (3.9%) never did. One woman gave no answer.

Parity in relation to the place of the last born is shown in Table 5.4.1

63 of 78 primiparous women delivered their first child in the hospital (80.8%)(see also 5.4.2.3) and 15 at home (19.2%). The majority of women, para 2 to 4, tend to deliver their last born in hospital and approximately half of the women with parity 5 and more tend to stay at home for their last deliveries.

Table 5.4.1 Relation of parity to place of delivery of the last born (n=306)

Parity	Number of women	Place of delivery of the last born: Place of Delivery Home	Hospital	% of Total Home	Hospital
1	78	15	63	19.2	80.8
2-4	130	51	79	39.2	60.8
5 +	98	50	48	51.0	49.0
Total	306	116	190	43.4	56.6
Unknown	24				

5.4.2 Interviews with clients of TBAs (n=31)

5.4.2.1 The motivation for visiting the Antenatal Clinic of the hospital

The question 'Why did you visit the Antenatal Clinic?' was answered by 31 women who were visiting the Maternal and Child Clinic and who had at least one experience of a delivery attended by a TBA. Twenty two of the 31 women (70.9%) indicated that they visited the Antenatal Clinic because of the (Western) medicines they received, while 5 women (16.1%) visited the Clinic for a general 'check-up' and/or an identification of the position of the foetus. The motivation of 4 women (12.9%) is unknown.

5.4.2.2 The number of previous deliveries and the place of delivery

The 31 women interviewed delivered a total of 95 times of which 72 times were at home* (75.8%) and 23 times in the hospital (24.2%) (see Table 5.4.2.2). This Table shows that 21 women (69.6%) delivered all their children including the first child at home: 11 women, parity 1; 4 women, parity 2; 2 women, parity 3; 2 women, parity 4; 2 women, parity 6.

Nine women delivered 19 times with the assistance of TBA 'Maame B', 5 other women 19 times with the assistance of 'Maame D', and 11 women were assisted 24 times by their own mother or grandmother. Seven of the 11 women who were assisted by their own relatives delivered a total of 19 times with the assistance of their *mother* while 4 women delivered 5 times with the assistance of their *grandmother*. The (grand)mothers may be defined as '*family*' TBAs who limit their services to their relatives only (see 1.3 and 5.4.3.3). Ten women delivered at home as well as in the hospital. Three women (no 21, 26 and 30) delivered a total of 13

* If assisted by a TBA women of Agogo usually delivered in their own house, but if there was no opportunity to deliver in that place they delivered in the house of a TBA. Unfortunately the pregnant women interviewed were not asked to give more detailed information on the place of delivery. For that reason a delivery 'at home' may refer to either the woman's own house or to the house of a TBA.

Table 5.4.2.2 Number of previous deliveries [parity] of 31 at random selected pregnant women of Agogo and the place of the deliveries either at home attended a TBA or in the hospital

Women	Parity	Number of deliveries assisted by TBAs/Maame* A, B, C, D, E, F, G, H	(Grand) mother**	Without assistance	Deliveries Home	Hospital
1	1		1		1	
2		1			1	
3		1			1	
4		1			1	
5		1			1	
6		1			1	
7		1			1	
8		1			1	
9		1			1	
10		1			1	
11			1		1	
12	2	2			2	
13			1		1	1
14			2		2	
15		2			2	
16			1	1	2	
17	3	2			2	1
18		3			3	
19		3			3	
20		1			1	2
21	4		1		1	3
22			4		4	
23		4			4	
24	5		3		3	2
25			3		3	2
26	6		1		1	5
27		6			6	
28		5			5	1
29			6		6	
30	7	2			2	5
31	9	8			8	1
Total		2 19 1 19 1 1 3 1	24	1	72	23

* In Agogo TBAs (and women in general) are addressed to as 'Maame'; A, B,C, etc. are used on account of discretion of the TBAs

** The (grand) mother may be the so-called '*family*'-TBA who is limiting her services to her relatives only (see 1.3 and 5.4.3.3)

times in the hospital. Only 1 woman indicated that she preferred to deliver in the hospital because of safety. The motivation of the other two women is unknown. From our data it could not be shown whether education of the women played a role to decide where to deliver.

5.4.2.3 THE TBAS WHO ASSISTED AND THE APPRECIATION OF THEIR WORK
Five of the 21 women who delivered all their children including the first child at home delivered with the assistance of a female relative (mother or grandmother) and 16 delivered with the assistance of a TBA. Five of the 10 women who delivered either at home or in the hospital were assisted by their grandmother and 5 women were assisted by a TBA. Fifteen of the 31 clients of TBAs expressed their appreciation of the work of the TBAs. Fourteen women were assisted by 2 TBAs ('Maame B' and 'Maame D'; see 5.4.2.2). All 14 women indicated that these TBAs were recommended by their own mother as being 'well-known', 'skillful' and/or 'pleasant'. The appreciation of the other clients is unknown.

5.4.2.4 SOME PRACTICES OF THE TBAS
Although the interviewed clients of the TBAs were not explicitly asked about practices of the TBAs the interviews revealed some additional information. Twenty two clients talked about their position during delivery: 8 of them delivered in a kneeling position, 14 in a lying position.
Eight clients indicated that the TBA had put a cloth against the anus during delivery and 19 clients indicated that the umbilical cord was cut with a blade. Six clients talked about the dressing of the umbilical cord: the TBAs had treated the cord with 'shea-butter' [a local fat], water and Eguro-leaves, or 'certain herbs'. The infant was bathed immediately after delivery according to 8 clients.

5.4.2.5 TYPE AND AMOUNT OF PAYMENT USUALLY GIVEN TO TBAS
Twelve clients did not answer the question about payment. Ten of the19 remaining clients paid the TBAs for their assistance in cash and 5 clients paid them in natura (often soap for cleaning the clothes used for the delivery). Four clients indicated that they did not pay at all. The amount of money given to the TBAs varied from 3 to10 Cedi equivalent to 1 to 3 US Dollar (1979/ 1980).

5.4.3 Interviews with TBAs

5.4.3.1 AGE
Inquiring about the exact age turned out to be of little use as 12 of the15 TBAs did not know their age. Two TBAs told explicitly that they had been born during the Yaa Asantewaa War (1900) which indicated that they were 80 years old at the time of the study. One TBA said she was 50 years old. Meeting the TBAs gave an opportunity of estimating their age: in general all the TBAs were middle-aged or elderly women.

5.4.3.2 THE WAY OF BECOMING A TBA
Of all the TBAs (n=15) interviewed 6 acquired their skills from the mother, one from the grandmother, one from the mothers' sister and seven from Onyame [God].

Most of the TBAs learned their practices from a female relative who happened to be a TBA. As a teenage girl the women accompanied their relative, usually a (grand)mother or an aunt. During the delivery they watched and listened. In order to become a TBA two essential conditions were required:

a a girl should not become sick at the sight of the 'filthy' work with blood,
b she should have the courage to deal not only with the catastrophic possibilities inherent at birth but also to deal with the possibility of bad influences from the world of spirits.

Almost half of the TBAs indicated that learned their practices from God. They stated that they were 'called' by Onyame. None of their relatives had been a TBA. [One of the TBAs turned out to be a 'fetish-priest' as well. When she was asked *how* she had become 'fetish-priest' she answered: "When I was born, Obosom [God] told me to become a fetish-priest. When I shall die, one of my children *runs the risk* of becoming a fetish-priest."]

5.4.3.3 The women they assisted: their clients

Twelve of the 15 TBAs mentioned that they assisted relatives as well as non-relatives. Three TBAs stated that they assisted relatives only. These 3 TBAs may be defined as '*family*' TBAs (see 1.3 and 5.4.2.2). The TBAs would never refuse to assist; only one TBA remarked that she would refuse in cases where she had been insulted: "I assist everybody, unless one has insulted me. Some women did not thank me after the delivery. I felt offended. I don't help those women anymore."

5.4.3.4 Type and amount of remuneration for their assistance

Inquiries about the remuneration turned out to be a delicate issue. TBAs in Agogo who got *money* for their assistance at birth were obliged to have a licence.* TBAs with a licence were liable to taxation. For that reason TBAs did not want to have a licence. They didn't want their remuneration in cash to be known as they were afraid of getting fined. Nevertheless a few TBAs admitted that they got money. Others got fees in natura (e.g. soap)(see also 5.4.2.5) and sometimes they were thanked with the words '*medase paa*' [thank you] only.

5.4.3.5 Contacts with other TBAs

There was hardly any contact between the individual TBAs. Nine of the 15 TBAs interviewed answered the question of whether they had any contact with other TBAs. The other 6 TBAs were not able to give adequate information: either a TBA broke off the interview as she didn't have time for it and the question was not repeated during the next interview, or a TBA refused to talk about it.

Six of 9 responders stated that they didn't have any contact with other TBAs at all. No reason could be obtained for this. Two TBAs who were living close to each other stated that they were friends and only 1 TBA (who turned out to be a

* Information about the necessity of a licence for TBAs could not be traced in literature.

prominent TBA in Agogo) indicated explicitly that she sometimes was asked for help and advice by another TBA. However other people of Agogo may have revealed why there is hardly any contact. During one of the interviews a TBA showed sudden annoyance with the interviewer when requested again to tell about her practices. The interviewer was puzzled by this unexpected reaction. After asking several people of Agogo about the possible reason for this reaction it was understood that the TBA – being aware of the fact that the interviewer was visiting other TBAs of Agogo regularly – was afraid that the information on her practices could be passed on to other TBAs which could have weakened the strength of her personal 'powerful' knowledge. From this limited information it may be assumed that mutual exchange of information between the TBAs hardly exists.

5.4.3.6 The role of Agogo Hospital in relation to the TBA practices

All TBAs stated that they do not provide any prenatal care. This was given by the Antenatal Clinic (AC) of Agogo Hospital. From the registration system of the AC it was noticed that many women of Agogo attended the Clinic. From the data of the questionnaires (see 5.3 and 5.4.1) it was found that a high percentage of women (95.4%) visited the Antenatal Clinic.* 22 out of 31 women interviewed who attended the AC indicated that they visited the Clinic because of the (Western) medicines they received (see 5.4.2.1).

The TBAs of Agogo made use of the presence of the hospital. They referred to the hospital in the case of a serious postpartum haemorrhage, obstructed labour, complicated breech delivery or intrauterine death. But they did this only after they had done their utmost to solve the problem themselves as they were very conscious of the fact that the hospital would solve it by means of an operation which in fact they did not like.

5.4.3.7 Practices and beliefs

The practices which have been discussed with 15 TBAs of Agogo are listed in Table 5.4.3.7.

As before (see Chapter 2) the practices are divided along the perinatal sequences: antenatal, intrapartum and postnatal. Unfortunately not all practices were discussed with each TBA. The number of TBAs giving the (same) answer is put in brackets. This means that the total number of answers of TBAs is included in the Table. The remaining answers are lacking because the practices were not discussed with the TBAs.

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* This figure is almost similar to a survey in the district Asante-Akim which showed that 299 out of 346 mothers interviewed (86.4%) received antenatal care from the Antenatal Clinic. [The survey was conducted from households selected at random from villages selected at random throughout the district] (Schaeffner 1985).

Table 5.4.3.7 Practices and beliefs of 15 TBAs in Agogo, Ghana

Obstetrical neonatal situation	Practices and beliefs of TBAs; [..] = the number of TBAs giving the (same) answer
The antenatal period *(physiological)*	
Prenatal care	– not giving any prenatal care [11]
The antenatal period *(pathological)*	
Intrauterine death	– slipping the whole arm into the uterus to get the child out [1] – sending to the hospital [1]
The intrapartum period *(physiological)*	
Second stage	
Position of the mother	– lying [3] – kneeling [2] – lying or kneeling [5]
Support of the perineum	– putting a cloth or sometimes a fist against the anus while supporting the perineum (otherwise the infant "would choose the wrong opening" resulting in the birth of a "wicked" child being predestined to die) [10]
The intrapartum period *(pathological)*	
First stage	
Obstructed labour	– inserting 'native medicines' into the anus [1] – praying [2] – sending to hospital [5]
Second stage	
Management breech presentation	– turning the child upside down ("it is necessary to get the child out as quick as possible, otherwise the child might be born via the anus and die") [1] – doing nothing ("because the child will come") [1] – sending to hospital [1] – slipping the hand into the uterus to get the feet out and after that the body and arms will follow [1] – never experienced [4]
Umbilical cord wrapped around the baby's neck	– slipping the loop of the u.c. around baby's neck as quickly as possible [1] – slipping the hand into the uterus to get the loop of the u.c. from the face side towards the back of the head and after that behind the arms [1]
Third stage	
Retained placenta	– pressing the abdomen and at the same time gently pulling the umbilical cord; otherwise manual removal (slipping the hand up to the wrist into the uterus) [1]

Table 5.4.3.7 Continuation

Obstetrical neonatal situation	Practices and beliefs of TBAs; [..] = the number of TBAs giving the (same) answer
	– pushing on the belly [2] – making the woman blow into a bottle or applying intrauterine native medicines on the placenta [1] – waiting and observing [1] – slipping the hand inside the vagina and pulling the u.c. [1] – applying intrauterine native medicines to the placenta [1] – placing the left leg of the woman across the right leg when the child is a girl; the other way around in the case of a boy [1] – sending the woman to hospital [1] – never experienced [1]
Postpartum haemorrhage	– giving the woman milk to drink [2] – giving oil from a sardine can mixed with water; or giving bananas to eat; or requesting the parturient to sit down on banana-leaves and giving the woman pieces of these leaves to chew and swallow [1] – giving bananas, mashed cocoyam [= a root crop] to eat [1] – giving mashed plaintain or 'kenkey' [= cooked, fermented maize] with sugar to eat [1] – giving a 'certain herb' [1] – praying [2] – if very difficult to solve, sending to hospital [2] – never experienced [5]
The postnatal period *(physiological)*	
Cutting of the umbilical cord – *how* –	– cutting with a *new* razor-blade [5] – cutting with a (used) razor-blade [5] – cutting with either a (used) razor-blade or a (sharp) knife [5]
– *when* –	– cutting after the birth of the placenta [8] – cutting sometimes before, sometimes after the birth of the placenta [1] – cutting sometimes before the birth of the placenta [2]
Dressing of the u.c. stump	– applying (with a chicken feather) a mixture of 'Topaee' (= chloramphenicol) powder and palm nut oil, before covering the stump with dry, heated, softened 'Nunum'-leaves* [1] – cleaning the stump with hot water and covering with heated, softened 'Nunum'-leaves [1]

Table 5.4.3.7 Continuation

Obstetrical neonatal situation	Practices and beliefs of TBAs; [..] = the number of TBAs giving the (same) answer
	– cleaning the stump with hot water and applying 'shea-butter' (a plant-oil)** [1] – applying juice from heated, softened 'Awansi-Awansi'-leaves only or with a mixture of palm-oil and pepper or salt [3] – cleaning the stump with hot water and penicillin-ointment [1] – applying a salt and earth mixture [1] – covering the stump with heated, softened 'Eguro'-leaves; when the stump drops, hot water and 'shea-butter' are applied [1] – applying 'Eguro'-leaves with oil and pepper or with salt and heated, softened bean-leaves [3] – applying 'a certain herb' [2] – applying salt and juice from tomatoes [1]
Care of the mother	– requesting the mother to close or cross her legs in order to prevent the entry of air into the body which may result in bleeding or a permanently fat abdomen [7]
Care of the placenta	– burying the placenta in a deep hole outside the compound [15]
The postnatal period *(pathological)*	
Immediate care of the asphyxiated newborn	– placing a finger with pepper in the baby's anus and at the same time a finger with pepper in the baby's mouth [1] – burning a herb so that the smoke will cause the baby to sneeze [1] – splashing and massaging the body of the baby with cold water [2] – putting a finger to the anus of the baby [to prevent the entry of air (= influence from evil spirits?) into the body: "you will die if too much air will go into your body!"], splashing the baby's face and massaging the body with water [2] – praying and splashing the baby's face with water [2] – praying, placing pepper or ginger in the mouth of the baby while splashing the baby's face with water [1] – placing an onion at the nose of the baby or sending to the hospital [1] – never experienced [2]

* (O)nunum = an aromatic herb

** The fruits of the *shea-butter* trees contain one or two seeds. Each seed contains a large, white kernel which is rich in oil known as shea-butter

5.4.4 Knowledge of students about TBAs and their practices

Students (n=58) of Form 5 (45 male and 13 female students, average age 21 years range 17-29) of the State Secondary School of Agogo gave written answers to a few questions concerning TBAs and their practices. Students (n=31/ all female, average age 21 years range 18-31) of the Teacher Training School of Agogo wrote an essay about everything they knew of TBAs and their practices.

5.4.4.1 Practices of TBAs

A few examples are given to give an impression of how the students described the practices of TBAs. For this purpose the practices are classified according to the common classifications in "Western" obstetrics (see Chapter II).

The intrapartum period *(physiological)*	
Immediate preparation of the delivery	"the TBA is putting ready a rag (on which the baby will lie), a blade, a thread, a pot (to put the placenta into the latrine), and an alcoholic drink like gin (this is given to the baby to wipe the throat"
Birth of the placenta	"the TBA is putting her hand on the stomach and pressing it downwards", or "tying the stomach of the woman with a piece of cloth to force the placenta out"
The intrapartum period *(pathological)*	
Prolonged labour	"giving some local herbs and salt to chew, or asking the woman to sit in warm water", "giving some herbs by enema", or "consulting a herbalist who gives some herbs for the woman to drink (the herbs are collected from the bush and grinded on a stone and mixed with water). Inserting some of these herbs into the vulva of the woman"
The postnatal period *(physiological)*	
Care of the infant	" bathing the child with warm water to which a bit of dettol is added. Smearing the child's skin with shea-butter or powder; then wrapping the child in a rag"

5.4.4.2 Appreciation of the work of TBAs

Appreciation of the work of TBAs expressed by the students has been simplified by subdividing them into positive and negative descriptions. Out of 89 (44 female; 45 male) students 37 (41.5%) talked in a positive and 20 (22.4%) in a negative way about TBAs and their practices. 32 Students gave no answer (35.9%) (see Table 5.4.4.2a).

Table 5.4.4.2a Appreciation of the work of TBAs expressed by 57 (out of 89) students in Agogo town, Ghana

School, number and sex of students		Appreciation positive	negative	unknown
Teacher Tr. School:	31 female st.	12 (38.7%)	7 (22.5%)	12 (38.7%)
State Sec. School:	13 female st.	5 (38.4%)	4 (30.7%)	4 (30.7%)
State Sec. School:	45 male st.	20 (44.4%)	9 (20%)	6 (35.6%)
Total	89 students (100%)	37 (41.5%)	20 (22.4%)	32 (35.9%)

There seems to be no remarkable difference between the female and the male students who expressed their appreciation of the work of TBAs:
- 17 of 28 female students (60.7%) and 20 of 29 male students (68.9%) gave positive descriptions, while
- 11 of 28 female students (39.2%) and 9 of 29 male students(31%) gave negative descriptions.

Two positive [out of 37] and two negative [out of 20] reactions are given to give an impression of the way in which their appreciation was expressed.

Positive reactions:

Student A:

"I would advise my wife to go to the TBA because of the safety of the work I have found [most probably the student refers to 'I have obtained the information' and not 'I have *attended* a delivery'; YL] and heard about this woman. It even has been said by some people that as she has gained experience in the work, immediately the child starts to come out of the womb. The action and the movement of the child would let the woman know whether the child is a male or female. An experienced midwife is better than the hospital."

Student B:

"A TBA can be described or can be defined as a woman who has good knowledge or ability in helping pregnant people in giving birth without being trained in any school. (...) The TBA I am talking about is well known in my village because she has wonderful herbs not only for delivering children, but she can also cure diseases."

Negative reactions:

Student C:

"The home-midwife is unskilled."

Student D:

"I would not go to the TBA because the herbs and tools she uses are very crude and I consider them not hygienic and they might cause infection."

37 of the 49 students [males and females] (75.5%) of the State Secondary School of Agogo (n=58) answered in preference of a delivery in the hospital (or would advise their future pregnant wives to deliver in the hospital) instead of a delivery attended by a TBA (see Table 5.4.4.2b).

Table 5.4.4.2b Preference for either a delivery in the hospital or a delivery attended by a TBA expressed by 49 (out of 58) students of the State Secondary School in Agogo town, Ghana

Number and sex of students		Preference		
		hospital	TBA	no reaction
	13 female students	10 (77%)	2 (15.4%)	1 (7.6%)
	45 male students	27 (60%)	10 (22.2%)	8 (17.8%)
Total	58 students (100%)	37 (63.8%)	12 (20.7%)	9 (15.5%)

There seems to be no remarkable difference between the female and male students among those students who expressed their preference for either a delivery in the hospital or one attended by a TBA:

- 10 of the 12 female students (83.3%) and 27 of the 37 male students (72.9%) preferred a delivery in the hospital,
- 2 of the 12 female students (16.6%) and 10 of the 37 male students (27%) preferred a delivery attended by a TBA.

Education in school, but also a strong belief in Western knowledge, medicines, injections and operations as shown below may have played an important role for their preference for the hospital. For example:

Reaction from a few females:

"If I would be pregnant I would go to the hospital rather than going to the traditional midwife, because the hospital midwife knows much more about deliveries than the traditional midwife. After delivery the hospital midwife will check if the child has any diseases and she will give you medicine to cure the baby. Also she will weigh the baby to know the weight."

"I would like to go to the hospital because there may be a point when you may need a doctor to operate on you, otherwise there would be trouble."

Reaction from a few males:

"If my wife is pregnant I will take her to the hospital because the doctor unlike the traditional midwife has machines to operate on the woman when she is unable to bring forth."

"I will advise her to go to the hospital because the traditional midwife uses her own intelligence to deliver the woman, whereas at the hospital they will use scientific methods which have been proved [to be good] by successful experiments."

To give an impression of how the preference for a delivery by a TBA was expressed a few examples are given:

Reaction from a female student:

"The TBA knows how to help during delivery so if I am pregnant I will go to her and she will help me during my delivery. All the women in the town know her so almost all the pregnant women in the town go to her for advice when they are pregnant and also deliver their babies through her help."

Reaction from a few males:

"If my wife is impregnated by myself I shall advise her to use the traditional method of bringing forth because there is no cost in such surgical operation."

"Supposing my wife is impregnated and is about to deliver a baby, I'll advise her to consult a TBA. Simply because it may be possible that I'm staying at a very remote area and then I may encounter transportation problem. On the other hand it would be for me to take her to the hospital due to financial hardship whereas a TBA will only charge me a dozen eggs."

Six of the 10 male students who preferred a delivery attended by a TBA pointed to the role of money (see also 5.4.4.3). However one has to realise that what the students *say* about their possible action in the future may differ totally from what they actually will *do*.

5.4.4.3 Payment for TBAs

The female students did not write about payment in cash for TBAs. Only three girls mentioned a 'gift' to the TBA:

"a special gift"

"a gallon of kerosine and a bar of soap"

"an egg, a gallon of kerosine and a bar of soap"

The male students mentioned payment in natura and most striking compared this with the high payment in cash for a delivery in the hospital (see also 5.4.4.2), e.g.:

"They say it waistes money to deliver at the hospital to pay a large amount while the woman can deliver at home without any cost."

"I would advise my wife to go to the TBA because going to the hospital is very costly these days."

"I would advise my wife to go to the TBA due to financial problems. A TBA will only charge a dozen eggs."

5.5 Discussion

Our fieldstudy revealed that the majority of *women visiting the Mother and Child Health Clinic* ['*Under Fives Clinic*'] (90.5%) were between 20 and 40 years of age. Most women (95.4%) visited the Antenatal Clinic. Many primiparous women (80,8%) delivered their first child in the hospital. Women, para 2 to 4, tended to deliver their last born in hospital while approximately half of the women with parity 5 and more tended to stay at home for their last deliveries (see 5.4.1).

The majority of interviewed *clients of TBAs* (70.9%) visited the Antenatal Clinic for the (Western) medicines they received. Other clients stated they visited the Clinic for a general 'check-up' and/or an identification of the position of the foetus (see 5.4.2.1). All clients (n=31) delivered a total of 95 times of which 72

times were at home (75.8%) and 23 times in hospital (24.2%). Twenty one of the 31 women (69.6%) delivered all their children including the first child at home. These data suggest that women seem to deliver their first child at home. This is not in agreement with the data of the at random selected women of the Maternal and Child Health Clinic (see 5.4.1). Two TBAs were more 'popular' than others. All women who were assisted by these TBAs (n=14) indicated that the TBAs were recommended by their own mother as being 'well-known', 'skillful' and/or 'pleasant'. In addition the mother or the grandmother often assisted with the birth. The mother assisted more often than the grandmother. These (grand)-mothers may be defined as '*family*' TBAs (see1.3 and 5.4.3.3).
Ten women delivered at home as well as in hospital. Three women delivered a total of 13 times in hospital. Only 1 woman indicated that she preferred to deliver in hospital because of safety. The motivation of the other 2 women is unknown. It could not be shown whether education of the women played a role to decide where to deliver (see 5.4.2.2 and 5.4.2.3).
Although the clients were not explicitly asked about practices of the TBAs the interviews revealed some additional information. Fourteen of the 22 clients indicated that they delivered in a lying position. The other 8 clients delivered in a kneeling position. Eight of the 31 clients stated that the TBA had put a cloth against the anus during delivery and 19 clients indicated that the umbilical cord was cut by the TBAs with a blade. Six clients stated that the umbilical cord was dressed with 'shea-butter'(a local fat), water and Eguro-leaves, or 'certain herbs'. The infant was bathed immediately after delivery according to 8 clients (see 5.4.2.4). This is similar to what the TBAs indicated about their practices (see 5.4.3.7).
The clients paid the TBAs either in cash or in natura (see 5.4.2.5). This is similar to what the TBAs and the students stated (see 5.4.3.4 and 5.4.4.3).

The interviews with the *TBAs* (n=15) revealed that the *characteristics* of the TBAs seemed to be similar to those in the studies of the Danfa Project (1971/1972) in the Greater Accra Region and to that of the National TBA Programme (1987) which was conducted in all the regions of the country (see 5.1.3):

- Inquiring about the exact age turned out to be of little significance as the majority (80%) did not know their age. Two TBAs told explicitly that they were born during the Yaa Asantewaa War (1900) which indicated that they were 80 years old at the time of the study. One TBA stated she was 50 years old. Meeting the TBAs gave the opportunity to estimate their age. They were all middle-aged or elderly women (see 5.4.3.1).
- Eight TBAs acquired their skills from a female relative (mother, grandmother or mother's sister) through apprenticeship and 7 TBAs indicated to have acquired their skills from Onyame [God] (see 5.4.3.2).
- Two types of TBAs could be identified: those who assisted relatives as well as non-relatives, and those who limited their services to their relatives only. The majority of the TBAs interviewed (75%) assisted relatives as well as non-relatives. The TBAs who assisted relatives only may be defined as '*family*' TBAs (see 1.3, 5.4.2.2 and 5.4.3.3).
- The TBAs received fees in cash or in natura [kerosine, soap, eggs etc] (see 5.4.3.4).

There seemed to be hardly any *contact between the TBAs.* Only 9 of the 15 TBAs interviewed answered the question about this issue. Six indicated that they didn't have contact with other TBAs at all. No reason could be obtained for this. Two TBAs who were living near each other stated that they were friends and 1 TBA who turned out to be a prominent TBA of Agogo indicated explicitly that she was sometimes asked for help and advice by another TBA. However our data indicate, and this is supported by discussions with several other people of Agogo, that mutual exchange of information between the TBAs hardly exists. TBAs seemed to prefer their practices to be kept secret from other TBAs (see 5.4.3.5).
The TBAs made use of *the nearby hospital.* In the case of a complicated obstetrical situation (eg. postpartum haemorrhage, obstructed labour) they referred the women to the hospital. But they did this only after they had done their utmost to solve the problem themselves (see 5.4.3.6).
Generally the TBAs spoke about their *practices and beliefs* to the interviewer (being an outsider) without hesitation (see 5.4.3.7). Unfortunately not all practices were discussed with each TBA. Practices in connection with complicated obstetrical situations (such as retained placenta, postpartum haemorrhage, immediate care of the asphyxiated newborn) and 'dressing of the umbilical cord' showed many differences between the TBAs. These practices may be the practices which seemed to be bound to the individual TBA (see 5.4.3.5). The following practices turned out to be more common to all or nearly all TBAs than those in connection with complicated obstetrical situations:

- giving no prenatal care [antenatal period],
- putting a cloth against the anus while supporting the perineum [intrapartum period],
- cutting the umbilical cord with a razor-blade,
- cutting the umbilical cord *after* the birth of the placenta,
- requesting the mother to close or cross her legs in order to prevent a bleeding,
- and burying the placenta [postnatal period].

These practices may be the practices performed as a matter of 'basic' routine. 'Supporting the perineum', 'cutting the umbilical cord with a razor-blade', 'cutting the umbilical cord *after* the birth of the placenta' and 'burying the placenta' are similar to the common practices of TBAs described from the literature in Chapter 2 in Africa, Asia and Latin America (see 2.5).
Putting a cloth against the anus was based on the belief that a 'wicked' child could be born via the anus. Requesting the mother to close or cross her legs was based on the belief to reduce the 'air' entering the body which could result into a bleeding and/or a permanently fat abdomen.
The lying as well as the kneeling position of the woman in labour was mentioned by the TBAs. This is similar to what the clients of the TBAs indicated (see 5.4.2.4).

Students of the State Secondary School (n=58) and the Teacher Training School of Agogo (n=31) (all young but relatively highly educated Akan people) revealed that they were well informed about the practices of TBAs in their home villages (see 5.4.4.1). This may indicate that they are brought up in close contact with female relatives, as many Asante women tend to live together with their children and

other female relatives separated from their husbands due to the matrilineal system (see 5.1.4.2).

There seemed to be no remarkable difference between the female (n=28) and the male students (n=29) who expressed their appreciation of the work of TBAs:

- 60.7% of the female students and 68.9% of the male students gave positive descriptions of the work of TBAs, whereas
- 39.2% of the female students and 31% of the male students gave negative descriptions (see 5.4.4.2).

In addition there seemed to be no appreciable difference between the female students (n=12) and the male students (n=37) who expressed their preference for either a delivery in the hospital or a delivery attended by a TBA:

- 83.3% of the female students and 72.9% of the male students answered that they preferred (or would advise their future wives) a delivery in the hospital, while
- 16.6% of the female students and 27% of the male students preferred a delivery attended by a TBA.

Education in school but also a strong belief in Western knowledge, medicines, injections and operations as shown in their answers may have played an important role in their preference for the hospital.

Six of the10 male students who preferred a delivery attended by a TBA pointed out the fact that TBAs were 'cheaper' than the hospital. In general one has to realise that what the students *say* about their action in the future it may be totally different to what they may *do*.

6 Final Discussion

The main goal of this publication has been to gain insight into the traditional midwifery in Africa, Asia and Latin America (see Introduction, pg. 2).
Three intermediate objectives were formulated:

1 comparing the role, practices and beliefs of Traditional Birth Attendants (TBAs) in different countries of the three continents,
2 broadening the insights into traditional midwifery in these countries by classifying the practices and beliefs of TBAs according to the common obstetrical classifications,
3 giving suggestions for a health policy with reference to the training of TBAs.

In *Chapter 1* general characteristics of TBAs in Africa, Asia and Latin America were reviewed from the available literature. Data were collected from anthropological and medical publications as well as from nursing journals.
A few characteristics of the TBAs appeared to be more or less similar on the three continents surveyed: in general they are older than 50 years, they are mostly women, they acquire their knowledge and skills from relatives and they usually do not depend on the incomes from the assisted deliveries for their subsistence. Other characteristics showed a wide diversity:

- There are different 'kinds' of TBAs: for example TBAs who do deliveries only occasionally mostly restricting their services to their own relatives ('*family*' TBAs), or TBAs who have a regular practice assisting their relatives as well as women who are not related to them, or TBAs who are spiritualists bringing a woman through her delivery by prayer and divine intervention.
- There is a great variety in the TBAs' experience of assisting at birth with reference to the number of deliveries performed annually by each TBA.
- TBAs receive different rewards for their services. They are generally 'paid' either in cash or in natura. As TBAs are part of the local community they are acquainted with the women they serve and the local customs. Therefore they know very well what kind of remuneration they can charge or may expect for their services.
- There is a wide diversity in the delivery practices and beliefs. They seem to be restricted to the social and cultural matrix of the group to which the TBA belongs. In addition they originate from and reflect underlying ideas and beliefs of the society concerning disease and health. For example:

a TBA interviewed told me that the immediate care of an asphyxiated newborn consisted of "placing a finger with pepper in the infant's anus and at the same time a finger with pepper in the infant's mouth". This is difficult to understand for Western standards. However it becomes more comprehensible when it is realised that in the Asante culture of the area studied it is a custom of many adults to occasionally clean their 'stomach' by using an enema made of a mixture of pepper and ginger. This is believed to be good for the health of a person. The TBA may have used this treatment for the infant as this practice was an integral part of the culture to which she belonged. In addition it is generally believed by the Ashanti people that pepper has the power of expelling evil spirits who may attack people through openings of the body. Therefore the TBA may have believed that pepper may protect the infant.

Despite the wide diversity of characteristics of TBAs the term TBA is meant to be used as a collective noun for all those persons who know how to assist women at childbirth. In this way TBAs are considered as one category or professional group (see 1.4, pg. 12). The concept of a professional group has been analysed in the sociological literature according to the following criteria:

- A professional group obtains a (long) training in a training-school, i.e. knowledge, skills, special rules and values are imparted to the trainees. An examination has to be passed at the end of the training in order to be admitted to the profession (professional selection).
- There is internal social control i.e. the professionials themselves make sure that colleagues act according to the rules and values of the profession. This is a condition which a society makes in connection with the legal protection of a profession.
- There is legal protection i.e. professionals are licensed to perform activities in exchange for money, things or services. In addition they have a mandate to decide what is the right attitude and way of acting of non-professionals with regard to professional matters.
- Responsibility for an important social value is required. Every society adopts and values certain organizing principles such as maintenance of law and order, economic planning, health etc. In the fields of law, economy, medicine etc. professionals have to dedicate themselves to these socially valued principles (Klinkert in Aakster 1984).

From the review of the literature it appeared that TBAs are not formally trained in a school, but have acquired their skills and knowledge during an apprenticeship with an experienced person, mostly an elder female relative. They don't have to pass an exam, but they will take over the work when the elder person wishes to retire (see 1.3.3). There is no internal social control with respect to the work. Knowledge and skills seem to be bound to the individual TBA and direct exchange of experience between TBAs seems not to exist. There is no legal protection of TBAs and responsibility for health as an important social value is not required because TBAs are not officially integrated into the formal health services. Taking these essential conditions into account it may be concluded that TBAs cannot be considered to be a professional group.

In *Chapter 2* the practices and beliefs of TBAs in different countries of Africa, Asia and Latin America have been compared in a review of the literature. The practices

and beliefs were systematically classified according to the common classifications in 'Western' medicine with reference to the perinatal period which was divided into the antenatal period, the intrapartum and the postnatal period. While making use of the available literature it was realised that the descriptions of practices and beliefs were not equally presented for the three continents. The quantity and quality of the data were very diverse. In addition the descriptions presented were usually based on interviewing TBAs and only in some occasions on observations of the practices. Since a real difference between attitudes and practices can be expected we should be aware that TBAs interviewed may act and behave totally differently from what they tell the interviewer. However regardless of all these shortcomings we considered that the information obtained was useful for comparison.

Comparison of the practices and beliefs of TBAs in *Africa, Asia and Latin America* revealed a large variety among the different cultures of the three continents. Surprisingly in spite of the cultural differences there were obviously *common practices and beliefs* which may occur in all three continents. For example:
during the intrapartum period *(physiological)*:
- recommending an upright position of the woman during the second stage of labour,
- lubricating the perineum with oil as a preparation of the birth process.

during the postnatal period *(physiological)*:
- cutting the umbilical cord *after* the birth of the placenta,
- leaving the umbilical cord long while cutting,
- providing the mother with warmth and/or smoke in order to benefit the purging and recovery process after the birth of the placenta.

It is assumed that these common practices are due to the expression people give to the basic events of life such as pregnancy, labour and lactation.

Comparison of the practices and beliefs of TBAs in *Africa and Asia* revealed some common practices and beliefs which may occur in the two continents.
For example:
during the antenatal period *(physiological)*:
- imposing the same kind of taboos on some activities during pregnancy with similar arguments. For example: standing in the doorway *(may cause obstructed labour)*, going for a walk and returning halfway *(may cause prolonged labour)*, bathing or walking at night *(may draw evil spirits)*, sleeping during daylight, or being lazy *(may cause a long delivery as the child may behave in the same way on its delivery day)*.

during the intrapartum period *(pathological)*:
- sometimes trying manual removal of a retained placenta,
- believing that postpartum haemorrhage is not alarming as it is considered a flow of 'bad' blood.

during the postnatal period *(physiological)*:
- cutting the umbilical cord at the distance of where it reaches the knees or head of the child while believing that touching the genitals should be avoided in order to prevent the child becoming infertile,

– stretching the limbs of the newborn.

during the postnatal period *(pathological)*:

– milking the umbilical cord as part of the immediate care of the asphyxiated newborn.

Comparison of the practices and beliefs of TBAs in *Asia and Latin America* revealed only one common practice possibly occurring in the two continents:

during the intrapartum period *(physiological)*:

– taking measures to prevent a possible attack of evil spirits on the house in which the delivery will take place.

Comparison of the practices and beliefs of TBAs in *Africa and Latin America* again revealed some common practices which may occur in one of these continents.

For example:

during the intrapartum period *(pathological)*:

– blowing into a bottle or gourd, inserting something into the throat to initiate vomiting or placing heated brandy near the vagina (or fumigation) in the case of a retained placenta.

during the postnatal period *(physiological)*:

– cutting the umbilical cord once it has stopped pulsating.

during the postnatal period *(pathological)*:

– putting a hot compress or blowing smoke on the anterior fontanelle as part of the immediate care of the asphyxiated newborn.

Comparison also revealed *different isolated practices* between the three continents as there were practices which seemed to occur separately in the countries of one continent.

For example:

– in *Africa:* during the intrapartum period *(pathological):*
  – performance of an episiotomy in the case of either a prolonged labour or a breech presentation,
  – or internal version in the case of a prolonged labour.
– in *Latin America:* during the postnatal period *(physiological):*
  – dressing of the umbilical cord by cauterising it in a candle flame.
– in *Asia:* during the antenatal period *(physiological):*
  – preparing sacrifices for ceremonies or rituals during pregnancy.

  during the postnatal period *(pathological):*
  – trampling on the placenta and/or roasting the placenta as part of the immediate care of the asphyxiated newborn.

In *Chapter 3* dietary advices as part of the birthing practices of TBAs in Africa, Asia and Latin America have been compared in a review of the literature. Information was mainly obtained from Africa, less from Asia and Latin America. Food taboos and/or foodrecommendations for the pregnant and lactating woman and her outcome were given with reference to the antenatal and the postnatal period.

The foods were presented according to the Nutritional Classification 'Basic Food Plan' in which every day food is classified as 'Foods for Growth' (in general protein rich products such as fish, meat, chicken, milk, nuts), 'Protective Foods' (vitamin and mineral rich items such as vegetables and fruits), 'Energy Producing Foods' (carbohydrate and fat rich products such as staple-foods, fats and oil, sugars) and 'water'.
Comparison of the dietary recommendations given by TBAs revealed common practices and beliefs. In all three continents there are often taboos on foodproducts during the antenatal period which contain *vitamins and minerals* ['Protective Foods'] for fear of a miscarriage. At the end of pregnancy there are often taboos on foodproducts which contain *protein* ['Foods for Growth'] and *carbohydrates and fats* ['Energy Producing Foods'] for fear the infant may grow too big because of the feared complication of a delayed or obstructed labour.
In Africa and Asia there are quite often taboos on foodproducts which contain *vitamins and minerals* ['Protective Foods'] in order to prevent skin problems. In addition there is the common taboo especially on eating twin bananas to prevent the birth of twins.

While foodproducts which contain protein ['Foods for Growth'] and carbohydrates and fats ['Energy Producing Foods'] are restricted at the end of pregnancy, they are commonly *recommended* (for the mother) in the postnatal period (lactation).

In Africa there are not many *foodtaboos for lactating women.* In Asia lactating women have to avoid 'hard', 'cold', 'wet' and 'sour' foods. These foods may be *protein* rich foods such as fish, eggs, grain legumes or milk, or *carbohydrate and fat* rich foods such as rice or potatoes.
In Latin America lactating women should avoid 'cold' foods. These 'cold' foods may be *protein* or *carbohydrate and fat* rich foods, but also *vitamin and mineral* rich foods such as beans, cabbage, avocado and fruits.

Newborns are generally breastfed in all three continents reviewed, but there is the common belief that colostrum should be discarded and that (mostly) water with sugar has te be given instead. In most areas colostrum is considered 'impure' and therefore unhealthy for the infant; its yellow colour may be looked upon with great suspicion and may often be associated with pus.

In *Chapter 4* trainingprogrammes of TBAs in Africa, Asia and Latin America have been discussed from the countries Sierra Leone, Liberia, the Gambia, Ghana, Thailand, the Philippines, India, Ecuador, Guatemala and Brazil. Training of TBAs was systematically started by the WHO in 1972 with the purpose of reducing maternal and perinatal mortality and morbidity. With the introduction of the Primary Health Care (PHC) policy (1978) the WHO recommended exploring the possibilities of engaging TBAs in PHC and training them accordingly. It was argued and propagated in a field guide about the training of TBAs published by the WHO (1979) that TBAs should work side by side ('articulation') with the organized formal health system, but they should not be integrated into the health system. In this way both the traditional and the organized health system

could coexist without conflicts. In order to give an insight into the policy concerning TBAs carried out in different areas of the three continents a description is given of the learning objectives, course content and evaluation of the performance of the trained TBAs. Reports of trainingprogrammes were selected which explicitly presented these aspects of the training for three countries of each continent. However we also selected from the continent Africa a description of all trainingprogrammes for TBAs in Ghana as these data were relevant to our fieldstudy (Chapter 5).

The reports of the trainingprogrammes reveal that in all three continents generally short training courses which may last from a few days to some weeks were (and are) given. Course contents of trainingprogrammes in Sierra Leone, Liberia, Thailand, the Philippines, Ecuador and Guatemala show that TBAs have to learn and become acquainted with many different topics commonly taught in Western countries within a short time span. This is very difficult, if not impossible, for TBAs who are usually old and illiterate. The way of teaching such as giving lectures, demonstrations, etc. and the teaching materials appear to be 'Western' and therefore unsuitable for TBAs who are not accustomed to this. With regard to their age TBAs have build up a lifelong experience and they will not easily give up or change their own traditional practices. These facts – resulting from the cultural difference between Western educated trainers and locally 'educated' TBAs (and their clients) – were obviously not taken into consideration when designing the trainingprogrammes. Only one programme could be traced in which a very sensitive problem-solving approach was adopted in order to bridge the cultural gap between trainers and TBAs (with their clients). A detailed inventory of the TBA's attitudes, knowledge and practices was carried out. On the basis of this inventory a trainingprogramme was designed. This programme aimed at changing harmful practices, encouraging beneficial traditional customs, reshaping attitudes and values, and adding new knowledge. It was realised that changing harmful practices required a sensitive approach. For example one practice considered to be harmful was 'giving newborns two spoonfuls of castor oil in the belief that a catharsis was necessary to remove the fluids of the womb ingested by the newborn during birth'. As it was understood that this often caused severe diarrhoea which may lead to dehydration and death it was attempted to modify this practice. TBAs were asked whether there were any alternative laxatives. They suggested honey, which was available in all villages of the project area. Through consensus it was decided to recommend a spoon of honey as a laxative for the newborn. This became a practice now widespread in the project area. A practice which was considered to be harmful was discouraged while avoiding the creation of psychological barriers to change.(The TBA training as part of the Comprehensive Health and Development Project at Pachod in India; see page 111).

Evaluations of the performance of trained TBAs as presented in the literature appeared to be restricted and methodologically of questionable value. Refresher courses were not reported (only the *need* for these courses) and supervision of the trained TBAs was minimal. It is therefore not possible to estimate the effect of the programmes *in the long term.* However the evaluations revealed that cooperation of the TBAs with the organized health system as proposed by the WHO has not (yet) been established. On a few occasions the training was successful in that trained

TBAs increased their activity during the antenatal period and seemed to refer more women to the health centres.* In several places training did not appear successful at all as trained TBAs reverted to their own traditional practices. There were indications that the clients of the TBAs played an important role as they may respond negatively to the trained TBAs. For example in Guatemala women did not want to accept the new practices of the TBAs and obviously preferred the attendance of TBAs who were not exposed to the trainingprogramme.

In *Chapter 5* a medical anthropological study of TBAs in Agogo in Ghana is presented. This study was carried out in 1979/1980 with the aim of gaining detailed information on the role, practices and beliefs of the TBAs. In this study emphasis was laid on the practices of the individual TBA and the role of a TBA within a group of TBAs. In addition this study gave the opportunity of obtaining the comments especially of mothers and young educated persons about the TBAs and their activities. Information about these issues hardly exists. In addition data were collected on the motivation of women to visit the Antenatal Clinic (AC) of Agogo Hospital. The study was performed in the following ways:

1 The nurses of the Mother and Child Health Clinic (MCH) ['*Under Fives Clinic*'] were asked to obtain information on age, education, tribe, the number of deliveries *(parity)* and the place of delivery of the last born of a randomly selected group of women who visited the AC and who delivered at home or in hospital.
2 Women (n=31) who visited the AC and had at least one experience of a delivery attended by a TBA were selected at random and interviewed in order to obtain information about their motivation to visit the AC. In addition the interviews would offer the possibility to find out more about the TBAs themselves and the womens' appreciation of the TBAs' practices. These expected clients of TBAs were especially asked about: a) their motivation to visit the AC, b) the number of deliveries and the place of previous deliveries, c) the TBA who assisted them and the appreciation of the TBA's work, d) some of the TBA's practices and e) the type and amount of remuneration they gave for the TBA's assistance.
3 Extensive interviews with TBAs (n=15) were carried out. As Agogo was divided into 10 sections an attempt was made to select at least 1 TBA in each section to get a sample of the TBAs equally distributed in the town. The interviews were rather 'open', but attempts were made to focus the conversations on: a) their age, b) the way they had become TBAs, c) their relations with their clients, d) the type and amount of payment for their assistance, e) their contacts with other TBAs, f) the role of Agogo Hospital in relation to their practices, and especially g) their practices and beliefs.

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* However an intervention study in Indonesia about the impact of training TBAs on the outcome of pregnancy revealed that TBAs would not be able to establish a reduction in maternal and neonatal mortality as long as these trainingprogrammes would not be supported by well equipped and adequately working referral centers (Alisjahbana 1993).

4 In order to find out exactly what young relatively educated people knew and could tell about TBAs and their practices students (n=60) of a secondary school in Agogo (47 male and 13 female students, average age 21 years, range 17-29) were selected and requested to give written answers to a few questions concerning TBAs. In addition students (n=31) of the Teacher Training School in Agogo (all female, average age 21 years, range 18-31) were selected and requested to write an essay on everything they knew about TBAs and their practices.

The study revealed that the majority of *women visiting the MCH* ['*Under Fives Clinic*'] (90.5%) were between 20 and 40 years of age. Most women (95.4%) intended to visit the AC.
Many primiparous women (80.8%) delivered their first child in hospital. Women, para 2 to 4, tended to deliver their last born in hospital while approximately half of the women with parity 5 and more tended to stay at home for their last deliveries.

The majority of 31 interviewed *clients of the TBAs* (70.9%) indicated their intention to visit the AC of the hospital because of the medicines they received. Other clients visited the Clinic for a general 'check-up' and/or an identification of the position of the foetus. Twenty one of these 31 clients delivered all their children including the first child at home. Two TBAs turned out to be more 'popular' than others. All women who were assisted by these TBAs (n=14) indicated that the TBAs were recommended by their own mother as being 'well-known', 'skillful' and/or 'pleasant'. In addition the mother or the grandmother often assisted with birth ('*family*' TBAs; see Chapter 1).
Ten women delivered at home as well as in hospital. Three women delivered a total of 13 times in hospital. Only 1 of these women indicated that she preferred to deliver in hospital because of safety. The motivation of the other 2 women is unknown. It could not be shown whether education of the women played a role in their decision where to deliver.
Although the clients were not explicitly asked about practices of TBAs the interviews revealed some additional information. Two-third of the clients indicated that they delivered in a lying position. The others delivered in a kneeling position. Nearly one third of the clients stated that the TBA had put a cloth against their anus during delivery and more than half of the clients indicated that the umbilical cord was cut by the TBAs with a razor-blade. The umbilical cord was dressed with 'shea-butter' (a local fat), water-and-'Eguro'-leaves, or 'certain herbs' according to 6 clients. The infant was bathed immediately after delivery according to 8 clients. This information is similar to what the interviewed TBAs indicated about their practices. The clients indicated that they paid the TBAs either in cash or in natura.

The interviews with the *TBAs* (n=15) revealed that the characteristics of the TBAs seemed to be similar to those in the studies of the Danfa project (1971/1972) in the Greater Accra Region and to that of the National TBA Programme (1987) which was conducted in all the regions of the country (see 5.1.3):

- The TBAs were all middle-aged or elderly women, and they were illiterate. Inquiring about the exact age turned out to be of little significance as the majority (80%) did not know their age. Two TBAs explicitly told that they were born during the Yaa Asantewaa War (1900) which indicated that they were 80 years old at the time of the study. One TBA stated she was 50 years old. Meeting the TBAs gave the opportunity to estimate that they were all middle-aged or older.
- Half of the TBAs acquired their skills from a female relative (more often the mother than the grandmother and on a few occasions the mother's sister) through apprenticeship while the others indicated they had acquired their skills from Onyame [God]
- Two types of TBAs could be identified: those who assisted relatives as well as non-relatives, and those who limited their services to their relatives only ['*family*' TBAs; see Chapter 1]. The majority of these TBAs (75%) assisted relatives as well as non-relatives
- The TBAs generally received fees in cash, or in natura [soap, kerosine, eggs etc.]

There seemed to be hardly any contact between the TBAs. Contact with other TBAs was discussed with 9 of 15 TBAs. Six of them indicated that they did not have any contact with other TBAs. No reason could be obtained for this. Two TBAs were living close to each other and stated that they were friends. One TBA who turned out to be a prominent TBA of Agogo explicitly indicated that she was sometimes asked for help and advice by another TBA. However our data indicate, and this is supported by discussions with several other people of Agogo, that mutual exchange of information between the TBAs hardly exists. TBAs seemed to prefer their practices to be kept secret from other TBAs.

The TBAs made use of the nearby hospital. In the case of a complicated obstetrical situation (eg. postpartum haemorrhage, obstructed labour) they referred the women to the hospital. But they did this only after they had done their utmost to solve the problem themselves.

The TBAs spoke about their practices and beliefs without hesitation to the interviewer because she was an outsider. Many practices were discussed (see 5.4.3.7). Unfortunately not all practices were discussed with each TBA. Practices in connection with complicated obstetrical situations (such as retained placenta, postpartum haemorrhage, immediate care of the asphyxiated newborn) and 'dressing of the umbilical cord' showed many differences between the TBAs. These practices may be the practices which seemed bound to the individual TBA and intended to be kept secret from other TBAs. Some practices turned out to be common to all or nearly all TBAs:

during the antenatal period *(physiological):*
- giving no prenatal care,

during the intrapartum period *(physiological):*
- putting a cloth against the anus while supporting the perineum,

during the postnatal period *(physiological):*
- cutting the umbilical cord with a razor-blade,
- cutting the umbilical cord *after* the birth of the placenta,

- requesting the mother to close or cross her legs in order to prevent a bleeding and/or a permanent fat abdomen,
- burying the placenta.

These practices belong to the physiological condition of the birthprocess and may be the practices performed as a matter of 'basic' routine. 'Supporting the perineum', 'cutting the umbilical cord with a razor-blade', 'cutting the cord *after* the birth of the placenta' and 'burying the placenta' are similar to the common practices which may occur in all three continents (as described from the literature in Chapter 2).
Putting a cloth against the anus turned out to be based on the belief that this prevented the birth of a 'wicked' child born via the anus. Requesting the mother to close or cross her legs during the postnatal period was based on the belief that it would reduce the 'air' entering the body which could result in a bleeding and/or a permanently fat abdomen.
In comparison with the upright position of the woman in labour the lying position was frequently mentioned by the TBAs as by the clients. This lying position may be due to Western influence from the nearby hospital.

The *students* (all young but relatively highly educated Akan people) revealed to be well informed about the practices of TBAs. This may be due to the fact that they are brought up in close contact to female relatives as many Asante women tend to live together with their children and other female relatives separated from their husbands.
There seemed to be no remarkable difference between the female and the male students who expressed their appreciation of the work of TBAs: 60.7% of the female students and 68.9% of the male students gave a positive description of the practices of TBAs whereas 39.2% of the female and 31% of the male students gave a negative description. A high percentage of both the female (83.3%) and male students (72.9%) expressed their preference for a delivery in hospital. A small percentage of the female (16.6%) and male students (27%) indicated the preference for a delivery attended by a TBA. Education in school but also a strong belief in Western knowledge, medicines, injections and operations as shown in their answers may have played an important role in their preference for the hospital. Six of 10 male students who preferred a delivery attended by a TBA pointed out the fact that TBAs were 'cheaper' than the hospital. They stated that the reward for the TBA's services was lower than the price which was charged in the hospital for the assistance at a delivery. However one has to realise that what the students *say* about their action in the future may for all kind of reasons differ from what they actually will *do* (as their decision may be influenced by others).

6.1 Concluding remarks

With reference especially to practical training of TBAs the following considerations are made.
The proposed cooperation between Western trained health workers and TBAs has turned out to be difficult to convert into reality.

With regard to the training of TBAs one has to take into account that:

- There is a fundamental difference between traditional midwifery and 'Western' obstetrics. 'Western' obstetrics is especially focused on the biological birth process and seems to be less dependent on the social and cultural surroundings as compared to the work of traditional midwives. 'Western' obstetrics is in broad outline universal all over the world and exchange of experience in writing and practice is common. TBAs are not a professional group. It appears that mutual exchange of experience between TBAs hardly exists.
- There is a fundamental difference in the way of thinking between Western people and people of traditional cultures in Africa, Asia and Latin America about the anatomy and physiology of the human body. Communication between Western trained health workers and TBAs may be difficult due to different basic views.

Socio-cultural exchange between totally different cultures needs time and can only proceed gradually. Therefore training of TBAs according to Western procedures and practices which are new and strange to TBAs may result into confusion. TBAs may become confused about their own traditional practices and beliefs, and even worse they may lose their identity in the social cultural setting. They may be condemned by their own clients and no longer requested for their attendance at births. Although it was realised that losing the identity of TBAs due to training-programmes has to be avoided (WHO 1979b), it still happens in reality. In fact this may be a great objection to TBA-training. Nevertheless it may be assumed that as the young women are changing their attitudes under the influence of modern times (they prefer to deliver in the hospital; see Chapter 5) TBAs will also adjust themselves to the new circumstances. In connection with this it may be noted that TBAs have been shown to welcome training (personal communication with TBAs in Ghana 1979/1980; Alisjahbana 1993). However, training of TBAs should mean gradual adaptation to new knowledge and principles at a level of understanding of the common TBA. Training of TBAs *without* a proper insight into the traditional midwifery seems neither realistic nor desirable.

In addition it is necessary to emphasize that trainers of TBAs, who are usually nurses and midwives working in hospitals, often do not have a positive attitude towards the practices of TBAs (personal impression from the communication with nurses and midwives in the fieldstudy 1979/1980; Anderson & Staugard 1988; Alisjahbana 1993). One has to be aware that these Western-trained health professionals usually have accepted the general *Western* view that TBAs perform 'harmful' practices which have to be eliminated in order to reduce maternal and neonatal mortality and morbidity. For a meaningful training of TBAs it may be recommended that the health professionals should be instructed to show respect for the practices of TBAs and, as Anderson & Staugard (1988) have stressed, "for the cultural conceptions and rituals relevant to the delivery situation".

In every place where TBAs are or will be trained we recommend that an inventory of the role, practices and beliefs of TBAs should be obtained. This can be realised within a short time. This publication could be helpful. With the obtained information an adapted trainingprogramme can be designed. Training may be restricted to one or two topics only. Focusing on one topic at once may be more realistic than focusing on many different topics in a short timespan. The topic(s) should be

selected in consultation with the TBAs. One TBA may be selected as a tutor; this TBA may be one of the few TBAs who are frequently requested for attendance as they are "well-known and recommended for their skills" (see Chapter 5). In addition the way of teaching has to be adapted. Traditionally TBAs have acquired their skills and knowledge in an apprenticeship with an elder experienced person. Therefore training methods such as role playing, demonstration, discussion and practice have to be adopted. Lectures alone may not be effective. In this way it may be possible to bridge the cultural gap between Western trained health workers and TBAs and a better relationship with TBAs may be established. Insight into the traditional practices and beliefs of TBAs may have the advantage of better cooperation with the TBAs, but may also lead to another perception of the obstetrical knowledge in Western countries. In Western obstetrics we see an increasing interest in the traditional birthpractices such as the upright position of the woman in labour. We expect that information on the common practices and beliefs in Africa, Asia and Latin America may be of value to Western obstetrics. In relation to this we may conclude with a remark of the gynaecologist Odent (Lancet 1989) about his intention to go to Africa "not to give the TBAs a refresher course, but to learn from them".

Summary

It is estimated that between 60-80% of all births in Africa, Asia and Latin America are attended by Traditional Birth Attendants (TBAs). TBAs are usually older women who have acquired their knowledge and skills from relatives. It has been tried to upgrade the performance of TBAs as a reaction to the view that the practices of TBAs may endanger mother and child. In the beginning of this century this was done by individual physicians or nurses on their own initiative, but from the early fifties official trainingprogrammes were organised in many countries. Training of TBAs was systematically started by the WHO in 1972. With the introduction of the Primary Health Care (PHC) policy in 1978 the WHO propagated that TBAs should be engaged in PHC and trained them accordingly. Training of TBAs is still widely promoted at present.
The proposed cooperation between Western trained health workers and TBAs in Africa, Asia and Latin America implies a confrontation of 'Western' obstetrics with traditional midwifery.
Gaining insight into traditional midwifery has been the main goal of this thesis. Three intermediate objectives were formulated:

- comparing the role, practices and beliefs of TBAs in different countries of the three continents,
- broadening the insights into traditional midwifery in these countries by classifying the practices and beliefs of TBAs according to the common obstetrical classifications,
- giving suggestions for a health policy with reference to the training of TBAs.

Chapter 1 describes general characteristics of TBAs. For example local names, the gender, the way one becomes a TBA and the number of deliveries performed annually by a TBA. Because of the wide diversity in characteristics the term TBA – meant to be used as a collective noun for all those persons who know how to assist women at childbirth – was discussed.

Chapter 2 presents a comparison of the practices and beliefs of TBAs in different countries of Africa, Asia and Latin America. The practices and beliefs have been systematically arranged according to the common classifications in 'Western' obstetrics with reference to the perinatal period. This period has been divided into the antenatal period, the intrapartum and the postnatal period. Comparison of the practices and beliefs of TBAs revealed not only a large variety among the different cultures of the three continents but also *common* practices and beliefs which may

occur in all three continents. It has been assumed that these common practices and beliefs, eg lubricating the perineum with oil in an attempt to minimize laceration, may be due to the expression people give to the basic events of life such as pregnancy, labour and lactation. In addition, comparison of the practices revealed different isolated practices between the three continents which seemed to occur separately in the countries of only one continent. For example, cauterising the umbilical cord in a candle flame has been explicitly reported in Latin America. There are also common practices and beliefs which may occur in *two* continents only. For example, believing that postpartum haemorrhage is not alarming as it is considered to be a flow of 'bad' [= menstrual;YL] blood has been reported in Africa and Asia.

Chapter 3 presents a comparison of dietary advice as part of the perinatal practices of TBAs in Africa, Asia and Latin America. Food taboos and/or food recommendations of TBAs have been described with reference to the antenatal and the postnatal period. The foods have been presented according to the Nutritional Classification 'Basic Food Plan' which is used for Health Education in tropical countries. In this 'Basic Food Plan' every day food is classified as protein-rich foods, foods rich in carbohydrates and fats, foods rich in minerals and vitamins, and water. Comparison of the dietary advice given by TBAs during pregnancy and lactation revealed common practices and beliefs. In all three continents there are often taboos on foodproducts during pregnancy which contain *vitamins and minerals* ['Protective Foods'] for fear of a miscarriage. At the end of pregnancy there are often taboos on foodproducts which contain *protein* ['Foods for Growth'] and *carbohydrates and fats* ['Energy Producing Foods'] for fear the infant may grow too big and subsequently may delay or obstruct labour. The foodproducts which are restricted at the end of pregnancy are commonly *recommended* for the mother during lactation.
Newborns are generally breastfed in all three continents reviewed. However there is the common belief that breastmilk produced during the first postnatal days *(colostrum)* should be discarded and that (mostly) water with sugar has te be given instead. In most areas colostrum is considered 'impure' and therefore unhealthy for the infant; its yellow colour may be looked upon with great suspicion and may often be associated with pus.

Chapter 4 discusses training programmes of TBAs. A description has been given of the learning objectives, courses content and evaluation of the performance of the trained TBAs in order to give an insight into the policy concerning TBAs in different parts of Africa, Asia and Latin America. Reports of trainingprogrammes which explicitly presented these aspects of the training were selected for three countries of each continent. The reports revealed that in all three continents generally short training courses – lasting from a few days to some weeks – were (and are) given. Course contents showed that TBAs have to learn and become acquainted with many different 'Western' topics within a short time span which may be difficult for TBAs who are usually old and illiterate. In addition the way of teaching and the teaching materials appeared to be 'Western' and therefore unsuitable for TBAs who are not accustomed to these techniques. Evaluations of

the performance of trained TBAs as presented in the literature appeared to be restricted and methodologically of questionable value. Refresher course were not reported and supervision of the trained TBAs was often neglected. It was therefore impossible to estimate the effect of the programmes in the long term. Nevertheless the evaluations revealed that cooperation of the TBAs with the organized health system as proposed by the WHO has not (as yet) been established. On a few occasions the training was successful in that trained TBAs seemed to refer more women to the health centers. In several places training did not appear successful at all as trained TBAs reverted to their own traditional practices.

Chapter 5 presents a fieldstudy of TBAs in Agogo town in Ghana which was carried out in 1979/1980. The aim of that study was to gain detailed information on the role, practices and beliefs of TBAs living near each other. In addition this study gave the opportunity of obtaining the comments especially of mothers and young educated persons about the TBAs and their activities. Information about these issues hardly exists. In addition data were collected on the motivation of women to visit the Antenatal Clinic (AC) of the hospital in the town.
Interviews with TBAs (n=15) revealed that the characteristics of the TBAs were similar to the characteristics of the TBAs as presented in the studies which were conducted elsewhere in the country. There seemed to be hardly any contact between the TBAs. In addition TBAs appeared to prefer their practices to be kept secret from other TBAs. However, they spoke about their practices and beliefs without hesitation to the interviewer because she was an outsider. Comparison of their practices revealed that some practices were common to all or nearly all TBAs. These practices turned out to be similar to the common practices which may be performed as a matter of 'basic' routine as reported in the literature (Chapter 2). Practices in connection with complicated obstetrical situations such as retained placenta or postpartum haemorrhage, and 'dressing of the umbilical cord' showed many differences between the TBAs. These practices may be the practices which seemed bound to the individual TBA and intended to be kept secret from other TBAs.
Interviews with clients of TBAs (n=31) revealed that 21 of them delivered all their children including the first child at home. Two TBAs turned out to be more 'popular' than others. They were recommended by the mother of the clients as being 'well-known', 'skillful' and/or 'pleasant'. In addition the mother or the grandmother often assisted with birth *('family'* TBAs). Although the clients were not explicitly asked about practices of TBAs the interviews revealed some additional information. This information was similar to what the interviewed TBAs indicated about their practices. The majority of the clients (70.9%) indicated their intention to visit the Antenatal Clinic of the hospital because of the medicines they received. Other clients (16.1%) visited the Clinic for a general 'check-up' and/or an identification of the position of the foetus.
Essays written by students (n=91) of 2 schools in Agogo town [female and male/relatively highly educated/ average age 21 years] revealed that they were well informed about the practices of TBAs. The majority of both the female and the male students gave a favourable description of the practices of TBAs. However, they expressed their preference for a delivery in hospital. As shown in their essays

education in school but also a strong belief in Western knowledge, medicines, injections and surgical interventions may have played an important role in their preference for the hospital.

Chapter 6 summarizes methods and results of every Chapter in a Final Discussion. The Chapter concludes with suggestions for health policy with reference to TBAs. It is hoped that this publication will provide information which will add to the improvement of existing trainingprogrammes.

Samenvatting

Naar schatting wordt 60-80% van alle bevallingen in Afrika, Azië en Latijns Amerika begeleid door traditionele vroedvrouwen. Traditionele vroedvrouwen zijn gewoonlijk oudere vrouwen die hun vaardigheden geleerd hebben van een voorganger. Zij zijn vaak verwant aan de kraamvrouwen. Op grond van de gedachte, dat het handelen van traditionele vroedvrouwen wel eens gevaarlijk zou kunnen zijn voor moeder en kind, heeft men getracht hun praktijken te verbeteren. In het begin van deze eeuw waren het individueel werkende Westerse artsen en verpleegsters, die op eigen initiatief traditionele vroedvrouwen bijschoolden. Begin vijftiger jaren werd in veel landen een begin gemaakt met het organiseren van officiële bijscholingsprogramma's voor deze vroedvrouwen. Een meer systematische aanpak van de bijscholing van traditionele vroedvrouwen door de Wereldgezondheids Organisatie (WHO) ging in 1972 van start. Bij de introductie van het 'Primary Health Care' (PHC)-beleid in 1978 (tijdens een Internationale Conferentie in Alma Ata) propageerde de WHO de traditionele vroedvrouwen binnen dit beleid in te schakelen en ze dienovereenkomstig bij te scholen. Tegenwoordig wordt bijscholing van traditionele vroedvrouwen op grote schaal gestimuleerd. Westers opgeleide gezondheidswerkers zijn veelal betrokken bij de training van deze vroedvrouwen. Deze samenwerking tussen Westers opgeleide gezondheidswerkers en traditionele vroedvrouwen in Afrika, Azië en Latijns Amerika leidt ook tot een confrontatie van de Westerse met de traditionele verloskunde.

Het hoofddoel van dit proefschrift is inzicht te krijgen in de traditionele verloskunde. Er zijn drie nevendoeleinden:
- een onderlinge vergelijking te maken van zoveel mogelijk gegevens uit de literatuur die betrekking hebben op de positie in de gemeenschap, de praktijken en ideeën van traditionele vroedvrouwen in verschillende landen van drie continenten (Afrika, Azië en Latijns Amerika),
- kennis te vergroten van de traditionele verloskunde door deze praktijken en ideeën in te delen volgens de algemene Westerse classificaties van de obstetrie met betrekking tot de perinatale periode,
- voorstellen te doen ten behoeve van het gezondheidszorgbeleid met betrekking tot de bijscholing van traditionele vroedvrouwen.

Hoofdstuk 1 beschrijft de algemene kenmerken van traditionele vroedvrouwen zoals benaming, geslacht, wijze waarop men traditionele vroedvrouw wordt en het aantal bevallingen dat jaarlijks begeleid wordt. Vanwege de grote verscheidenheid aan

kenmerken worden er vraagtekens gezet bij het gebruik van de term 'traditionele vroedvrouw' voor alle personen die de zwangere kunnen bijstaan bij de bevalling.

In *Hoofdstuk 2* worden in een literatuuronderzoek de praktijken en ideeën van traditionele vroedvrouwen in verschillende landen van Afrika, Azië en Latijns Amerika op een systematische manier vergeleken aan de hand van de algemeen geldende classificaties in de Westerse obstetrie met betrekking tot de perinatale periode. Deze periode is onderverdeeld in de antenatale periode, de intrapartum periode en de postnatale periode. Vergelijking van de praktijken en ideeën van de traditionele vroedvrouwen laat niet alleen grote verschillen zien, maar ook *overeenkomstige* handelwijzen en ideeën die in alle drie de continenten voorkomen. Een voorbeeld is het insmeren van het perineum met olie om inscheuring te voorkomen. Er wordt geopperd, dat deze gemeenschappelijke praktijken en ideeën voortvloeien uit het feit, dat mensen op dezelfde wijze omgaan met zwangerschap, bevalling en borstvoeding. De vergelijking laat tevens zien, dat er praktijken zijn, die slechts in één continent voorkomen. Bijvoorbeeld het dichtschroeien van de navelstreng met behulp van een kaarsvlam lijkt uitsluitend in Latijns Amerika toegepast te worden. Ook zijn er praktijken en ideeën, die alleen in twee continenten voorkomen. Bijvoorbeeld het idee, dat een hevige nabloeding niet ernstig is – omdat men ervan uitgaat, dat een hoeveelheid 'vies' bloed na maanden zwangerschap eruit moet – lijkt alleen te bestaan in Afrika en Azië.

In *Hoofdstuk 3* wordt een onderlinge vergelijking gemaakt van de voedingsadviezen die de traditionele vroedvrouwen tijdens de perinatale periode verschaffen. Zowel taboes als aanbevelingen worden hierbij beschreven. De voedselsoorten zijn ingedeeld volgens de gangbare classificatie van voedingsstoffen (Nutritional Classification 'Basic Food Plan'), die gebruikt wordt bij gezondheidsvoorlichting in tropische landen. Het dagelijkse voedsel wordt daarin onderverdeeld in eiwitrijke voedselsoorten, in voedselsoorten die rijk zijn aan koolhydraten en vetten, in voedselsoorten die rijk zijn aan mineralen en vitaminen, en water. Een vergelijking van de voedingsadviezen die aan zwangere en lacterende vrouwen wordt gegeven, laat overeenkomsten zien. In alle drie de continenten rust er tijdens de zwangerschap vaak een taboe op voedselsoorten die vitaminen en mineralen bevatten, uit vrees voor het opwekken van een miskraam. Aan het einde van de zwangerschap zijn er taboes op eiwitrijke voedselsoorten en voedselsoorten die rijk zijn aan koolhydraten en vetten, uit angst voor een te sterke groei van het kind, waardoor een moeilijke bevalling veroorzaakt zou kunnen worden. Echter, deze voedselsoorten worden gewoonlijk wel *aanbevolen* aan moeders die borstvoeding geven.
In het algemeen krijgen pasgeborenen in alle drie de continenten borstvoeding. Opvallend is, dat borstvoeding van de eerste dagen (het 'colostrum') in het algemeen ontraden wordt. In de plaats daarvan wordt (meestal) water met suiker gegeven. In veel gebieden wordt het colostrum als 'onrein' en daarom ongezond voor de pasgeborene geacht. Met name de gele kleur van colostrum wordt met grote achterdocht bezien en vaak met pus geassocieerd.

Hoofdstuk 4 beschrijft diverse bijscholingsprogramma's voor traditionele vroedvrouwen om inzicht te krijgen in het gevoerde beleid met betrekking tot de

traditionele vroedvrouwen in Afrika, Azië en Latijns Amerika. De vorm en inhoud van de curricula alsmede het effect van deze training op de uitvoering van de traditionele vroedvrouwen *na* de bijscholing worden beschreven. Hiervoor werden rapporten van bijscholingsprogramma's, die expliciet ingingen op vorm, inhoud en effect van de bijscholing, geselecteerd uit drie landen van ieder continent. In alle drie de continenten worden in het algemeen korte cursussen gegeven – in duur variërend van een paar dagen tot soms een paar weken. Uit de beschreven leerstof is gebleken, dat traditionele vroedvrouwen in een kort tijdsbestek moeten leren omgaan met vele verschillende 'Westerse' onderwerpen. Voor mensen die gewoonlijk oud en ongeletterd zijn, is dat heel moeilijk. Bovendien waren de methodieken van onderricht geven en het onderwijsmateriaal te 'Westers' en daarom minder toegankelijk voor mensen die hier niet aan gewend zijn. De evaluaties met betrekking tot het effect van de training op de praktijkvoering van de vroedvrouwen *na* de bijscholing bleken inhoudelijk beperkt en methodologisch van twijfelachtige waarde. Herhalingscursussen ontbraken en supervisie werd vaak verwaarloosd. Om deze redenen was het niet mogelijk een oordeel te geven over het effect van deze programma's op lange termijn. Niettemin kwam uit de evaluaties naar voren, dat samenwerking van de traditionele vroedvrouwen met het georganiseerde gezondheidszorgsysteem, zoals door de WHO voorgesteld, nog niet is bereikt. In een enkel geval leek de bijscholing ertoe bij te dragen, dat traditionele vroedvrouwen meer zwangeren naar de gezondheidscentra verwijzen. In verscheidene plaatsen bleef de bijscholing zonder effect, zodat de traditionele vroedvrouwen weer terugvielen op hun 'eigen' oude praktijken.

Hoofdstuk 5 beschrijft eigen onderzoek van traditionele vroedvrouwen, dat in de plaats Agogo in Ghana in 1979/1980 plaatsvond. Het doel van het onderzoek was het verkrijgen van gedetailleerde informatie over de positie in de gemeenschap, alsmede over de praktijken en ideeën van een groep traditionele vroedvrouwen, die dichtbij elkaar wonen. Hierbij werd ook gelet op de interactie van deze vroedvrouwen op elkaars handelen. Bovendien bood het onderzoek de mogelijkheid om te weten te komen hoe vooral moeders en relatief hoog opgeleide jonge mensen dachten over de traditionele vroedvrouwen en hun praktijken. Informatie hierover is er nauwelijks. Tevens werden er gegevens verzameld over de motivatie van vrouwen om de kliniek voor zwangerschapscontrole van het Agogo ziekenhuis te bezoeken.
Uit de interviews met traditionele vroedvrouwen (n=15) kwam naar voren, dat de algemene kenmerken van hen overeenkwamen met wat elders in Ghana hierover werd gerapporteerd. Er bleek nauwelijks enig 'beroepsmatig' contact tussen de traditionele vroedvrouwen van dit onderzoek te zijn. De traditionele vroedvrouwen gaven er zelfs de voorkeur aan hun praktijken geheim te houden voor andere vroedvrouwen. Zij spraken echter zonder enige aarzeling over hun praktijken en ideeën tegenover de onderzoekster, aangezien zij als een buitenstaander werd beschouwd. Vergelijking van hun praktijken liet zien, dat enkele praktijken bij (nagenoeg) alle vroedvrouwen voorkwamen. Deze praktijken bleken overeen te komen met de gemeenschappelijke praktijken die als basisroutine werden omschreven in hoofdstuk 2. Er bleken echter ook vele verschillen in het handelen te bestaan tussen de traditionele vroedvrouwen vooral voor wat betreft de praktijkvoe-

ring van meer gecompliceerde obstetrische situaties, zoals een niet loslatende placenta of een hevige nabloeding alsook de verzorging van de navelstreng van de pasgeborene. Deze specifieke praktijken lijken gebonden te zijn aan de individuele traditionele vroedvrouw en daarom geheim te moeten blijven voor andere vroedvrouwen.
Uit interviews met cliënten van traditionele vroedvrouwen (n=31) is gebleken dat bij 21 van hen alle kinderen inclusief de eerste thuis waren geboren. Twee traditionele vroedvrouwen bleken geliefder dan de andere. Zij waren door de eigen moeder aanbevolen als 'goed bekend', 'kundig' en 'aardig'. In vele gevallen hielp de eigen moeder of de grootmoeder bij de bevalling. Hoewel er bij de cliënten niet expliciet gevraagd was naar de praktijken van de traditionele vroedvrouwen gaven de interviews toch aanvullende informatie. Deze informatie verschilde niet duidelijk van datgene wat de traditionele vroedvrouwen zelf hadden aangegeven over hun praktijken. De meerderheid van de moeders (70,9%) gaf aan, dat zij vooral de kliniek voor zwangerschapscontrole in het ziekenhuis bezochten vanwege de medicijnen die ze daar kregen. Voor andere moeders (16,1%) was de belangrijkste reden voor een bezoek aan de kliniek een algemene controle of een bepaling van de ligging van de foetus. Uit opstellen geschreven door 'onervaren' leerlingen (n=91) van twee scholen in Agogo [meisjes en jongens, relatief hoog opgeleid, met een gemiddelde leeftijd van 21 jaar] bleek, dat zij goed op de hoogte waren van de praktijken van traditionele vroedvrouwen. De meerderheid van zowel de meisjes als de jongens was positief over de praktijken van de traditionele vroedvrouwen. Niettemin gaven zij in het algemeen de voorkeur aan een bevalling in het ziekenhuis. Uit hun beschrijvingen bleek, dat de voorkeur voor het ziekenhuis mede bepaald wordt door een groot vertrouwen in de Westerse medische kennis, in Westerse geneesmiddelen en de operatieve mogelijkheden.

In *Hoofdstuk 6* worden de methoden en resultaten van elk hoofdstuk in het kort samengevoegd en nader besproken. Het hoofdstuk wordt afgesloten met voorstellen voor een gezondheidszorgbeleid met betrekking tot de bijscholing van traditionele vroedvrouwen. Dit boek zou een handleiding kunnen zijn voor het aanpassen van bijscholingsprogramma's.

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Appendices

Appendix 1a

Course content of a 3-week training session for TBAs in Sierra Leone

First week: maternal care
Registration; introduction
The role of the TBA at the village level
Personal hygiene
Reproductive system
Case-finding
Inspection of the home regarding its suitability for delivery
Home visiting
Booking patient for antenatal care
Examination of the patient at the first visit

Antenatal clinic; operation of the clinic
Examination during antenatal period
Nutrition during pregnancy
Anaemia
Recognition of the danger signs in pregnancy and when to refer to hospital for delivery
Preparation of mother for labour and delivery
Equipment for delivery
Labour – first, second, and third stages; management and danger signs in each stage
Record-keeping during labour and delivery
Demonstration of delivery
Care of the newborn
Resuscitation
Care of the umbilical cord – at birth and until the cord drops off
Examination and bathing of the newborn
Care of the eyes
Passage of urine and meconium
Cleaning up after delivery

Care in the puerperium
Examination of the mother: breast, abdomen, fundal height, lochia, bladder; urine retention problems
Establishment of breastfeeding
Swabbing and vulval toilet

Care of the premature baby
Feeding of new infants who cannot breastfeed

Feeding of the premature infant
The sick baby: diagnosis and management

Case demonstration
General discussion

Second week: child care and community health
The maternal and child health clinic (under-5 clinic)
The need for the infant to be seen regularly even if well
Immunization: programme and needs
The use of antimalarials
The weight chart

Feeding and nutrition

Nutrition (continued)
Breastfeeding
Weaning foods
Danger periods in the child's life
The high risk or 'at risk' child
Malnutrition: recognition, prevention, and treatment
Beliefs and customs associated with childbearing and child-rearing

The common diseases in children: recognition and emergency treatment
Emergency treatment of fever, convulsions, frequent stools, and vomiting
Relationship between some communicable diseases and infections and nutrition

Community health
Environmental sanitation
Home visiting
Relationship between health workers and the TBA in the village

Evaluation of the course. Presentation of certificates to TBAs and distribution of UNICEF kits. Closing.

Third week: practicals and family planning
Health centre practice and observation
Home visiting; family planning
Child spacing and need for this
Continuation of practical experience

Source: West, 1981a

Appendix 1b

Course content of a training programme for TBAs in Liberia

Antenatal care
Identifying anaemia; pre-eclampsia
Estimating gestation; recognizing previous caesarean section scar
Identifying presentation; recognizing normal foetal heart; recognizing multiple pregnancy
Recognizing high-risk mothers; recognizing harmful signals in pregnancy
Conducting home visits; doing case finding; giving health education
Managing minor disorders
Making proper referrals

Intrapartum
Distinguishing between true and false labour
Preparing patient, equipment, and area for delivery
Observing contractions; knowing normal duration of labour
Observing for signs of full dilatations; estimating time of delivery
Coaching patient to 'push' appropriately
Managing delivery and inspecting the placenta; recognizing complications and making referrals
Giving immediate care to the baby and the mother
Managing haemorrhage in emergency

Newborn and children
Giving proper cord care; identifying abnormalities and danger signals in the newborn; making referrals
Transferring low birth weight babies in the proper way
Teaching mothers proper breast-feeding techniques
Managing common ailments like fever, diarrhoea, etc. in newborns and older children, and making appropriate referrals

Family planning
Teaching child spacing; encouraging modern methods of child spacing
Identifying families who need child spacing advice and refer
Identifying families with problems of infertility

Source: Lartson et al.,1987

Appendix 1c

Course content of a 10 day (= 10 sessions) training programme for TBAs in the Philippines

Session 1 Orientation	Discussion on the purpose of the training, the number of women likely to seek the TBA's services, common harmful practices of TBAs, the advantages of a good relationship between TBA and local health service personnel.
Session 2 Infections	Discussion on the concept of harmful organisms (how they relate to certain illnesses of mothers and children, how they originate, and how their development may be prevented by the TBA and the mother), and on the basic principles of clean hands, clean supplies, and clean utensils.
Session 3 Delivery kit	Explanation and demonstration of the use of each item in the kit. Instruction is provided on how to maintain the kit and its contents in a state of cleanliness and how to sterilize the instrument in preparation for their use.
Session 4 Care during pregnancy	Discussion on the concept of prenatal care and its importance, the normal changes that occur in the pregnant woman and their significance, how to relieve certain minor discomforts of pregnancy,the signs and symptoms that suggest abnormalities requiring referral to health personnel, and the recognition of high-risk pregnancies and the need for referral.
Session 5 Care during labour	Discussion on the TBAs' traditional beliefs and practices with respect to pregnancy, labour, and delivery, "the rationale underlying them, and the danger inherent in some of them". Instruction of the techniques of safe assistance during labour and delivery, and on signs and symptoms that suggest the need for referral to health personnel.
Session 6 Care of the newborn	Instruction on how to stimulate respiration, to cut and dress the cord, to identify signs and symptoms indicating the need for referral, and general principles of early infant care, including breastfeeding. Discussion on traditional beliefs and practices concerning the newborn, in particular those related to cord management.
Session 7 Postnatal care	Discussion on the normal puerperium, the signs and symptoms that indicate the need for referral, the importance of breastfeeding, the danger inherent in improper methods of bottle-feeding, the importance of the mother's personal hygiene and proper nutrition. In this session also discussion on traditional beliefs and practices that are likely harmful.
Session 8 Birth registration	Instruction on how to record data on births in a booklet given to each TBA. Illiterate TBAs are encouraged to seek help of literate persons.
Session 9 Family planning	Discussion on the implications of frequent pregnancies and large families for the health and welfare of the family, on methods of contraception, and on the role of the TBA in recruiting family planning acceptors.
Session 10 Summary and follow-up	TBAs are encouraged to express their opinion of the course and what they feel they have learned. Arrangements are also made for the monthly supervision of the TBAs.

Source: Mangay-Angara, 1981

Appendix 1d

Course content of a trainingprogramme lasting 2 weeks to 6 months for TBAs in Guatemala

General hygiene	Personal hygiene: washing hands, having clean clothes, hair, nails and mouth; domestic: having clean floors and walls, having light and ventilation, clean water, using latrines, separating domesticated animals from the house, having a garbage disposal system.
Midwifery kit	Demonstration of the preparation, arrangement and use of 24 items in the kit.
Pregnancy	Western notions on human reproduction, changes during pregnancy, child development in utero, physical and mental hygiene, and nutrition during pregnancy. Instruction on how to recognize complication and troubles during pregnancy, e.g. nausea, gas, cramps, vaginal discharge, edema etc.
General facts about birth	Teaching the difference between normal and abnormal births i.e. abnormal positions, haemorrhage, abnormal respiration, physical defects, change in skin color etc.

Source: Greenberg,1982

Appendix 2

Questionnaire used in the Under Fives Clinic

Name:

Age:

Education:

Tribe:

Total number of deliveries:

Place of delivery of the last born: at home in the hospital

Did you attend Antenatal Clinic:

Appendix 3

Questions used in interviews with clients of TBAs

1 Was your first delivery at home?
2 Did you have more deliveries at home?
3 In which section of Agogo do you live?
4 Who was your birth attendant?
5 Was she [or he] a relative?/ Is she (usually) assisting other women as well?
6 Was the TBA assisting alone? Were other people present?
7 Did you know the TBA already? And why did you choose *her*?
8 Did you choose the TBA yourself or were you advised (in relation to your choice)?
9 In which position did you deliver?
10 What did the TBA actually do?
11 Was the delivery easy, or was it difficult?
12 How did the TBA cut the umbilical cord?
13 How was the newly-born baby treated immediately after birth?
14 Did you get something to eat after the delivery?
15 Did you pay the TBA afterwards?
16 Did you pay yourself or did a relative pay the TBA?
17 Were you satisfied with the assistance of the TBA?
18 Did your mother deliver at home? and who assisted her?
19 Why did you visit the Antenatal Clinic of the hospital?
20 Personal data
   - age:
   - education:
   - church:
   - name:

Appendix 4

Three questions presented to students of the State Secondary School of Agogo with the request to answer them truthfully

1 Could you please give *a short description* (or maybe more) of a *Traditional Birth Attendant* in your home-town? (Tell about sex, age, additional activities etc.)
2 Could you please write down *everything* you know about *the work* of the *Traditional Birth Attendant?*
3 If you (or your wife) would be pregnant, would you (or would you advise to) *go to a Traditional Birth Attendant or would you go to the hospital? Why?*

Appendix 5

Example of an essay written by a female student of the Teacher Training School of Agogo (age: 21 years/ tribe: Ashanti/religion: Presbyterian)

The TBA

A TBA can be described or can be defined as a woman having good knowledge or ability in helping pregnant people in giving birth without being trained in any school.
Anyway, I have seen many TBAs, but I would like to talk about one I know in my village. Despite the fact that doctors are there helping pregnant women, TBAs are also helping people in villages and town. When anyone is pregnant getting to the day of giving birth they would call the TBA. When this woman comes and sees her she would ask her to sit on the floor and loose herself. Then the TBA would ask the pregnant to try to 'push' so that the baby will come. If the baby is not coming in time she will use her medicine that are herbs at times. She uses them and prepares soup for the one to drink. So immediately she drinks the soup the baby will come sharp. When the baby comes she will bath him or her and dress him/her nicely and puts him/her on a bed.
The woman I am talking about is well known in my village because she has wonderful herbs not for delivering children alone, but also she can cure diseases. She helps sick people also especially those who have been attacked by fever, she has special medicine for that.
TBAs are useful in villages because there may be a typical village where there is no hospital. People may walk all the way to the hospital.

Acknowledgements

I am grateful to all persons who have helped to make this thesis possible. I would like to thank most particularly for their assistance:

Prof. Dr E. R. Boersma, my 'promotor' who, as a paediatrician, had the courage to invite me, as an anthropologist, to write this thesis. Rudy, I will be ever grateful for your confidence in me and our interdisciplinary co-operation. During the past four years I have never ceased to be impressed by your consistent precision for details and I have learnt a great deal from our discussions.

Prof. Dr J.D. Speckmann who as a colleague played a very stimulating role in the writing of this thesis. Hans, your positive criticism and wisdom were invaluable. I very much appreciated your support in explaining the anthropological viewpoint to the medical professionals.

Dr H.W.A. Voorhoeve who was the one who prompted me to begin writing this thesis and followed this up with stimulating discussions all those four years. Henk, your contribution has been enormous. Your tenacity has always refreshed my enthusiasm and your hospitality will always be remembered.

Dr H.W. Oudesluys-Murphy, who corrected the English text, is gratefully acknowledged. Anne Marie, I truly appreciate that as a paediatrician and mother you still could find time for me.

I wish to thank Prof. Dr Ch.P.J. Legein. Charles, your great experience in working with a computer and your assistance were indispensable for the completion of this thesis.

The members of the promotion committee Prof. Dr H.J. Huisjes, Prof. Dr C.J. de Groot and Prof. Dr A. Niehof who took time to examine this manuscript are cordially thanked.

I feel deep respect for the way in which my caring parents taught their children the importance of the search for knowledge.

Last but not least I like to thank Ton. His love and tender support have uplifted my spirit in moments of doubt.
Geeske, Friso and Sarah, your patience with a mother who had other things on her mind will not be forgotten.

Curriculum Vitae

The author of this thesis was born in 1947 in Heerlen, The Netherlands. In 1967 she finished her Secondary School education (gymnasium-B) and then went on to obtain her teacher's degree in Social Geography, graduating in 1972.
From 1972 until 1975 she lived in Tanzania. Upon returning to The Netherlands, she studied Cultural Anthropology at the University of Groningen. This was interrupted by a return visit to Africa (Ghana) where she began her research on Traditional Birth Attendants. In 1985 she graduated as a Cultural Anthropologist. From 1989 until 1991 she had an exhibition on Traditional Birth Attendants in several museums in The Netherlands. In april 1994 her exhibition on pregnancy and birth in Africa was opened in the Africa Museum, Berg en Dal.
She is married to Anthony Lefèber and is the mother of Geeske, Friso and Sarah.